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REPORT OF ONE HUNDRED AND FORTY-FIVE OPERATIONS DONE FOR REMOVAL OF OVARIAN TUMORS AND PATHOLOGICAL CONDITIONS ASSOCIATED WITH THE OVARIES AND UTERINE APPENDAGES ONLY.*

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IN presenting this report in abdominal surgery, with accompanying table, I desire to state that the one hundred and forty-five cases do not include any of my work in supravaginal hysterectomy, excepting Nos. 112 and 114, cases complicated with ovarian tumors, or solid tumors of the ovaries or broad ligaments, cases of hystero-epilepsy, cases of tuber-

*An abstract of this paper was read at the meeting of the American Association of Obstetricians and Gynæcologists, Toronto, Canada, September 19th, 1894.

cular peritonitis, of gall-bladder surgery, of appendicitis; or of any operations whatever within the peritoneal cavity, previously reported by myself in former papers, with one exception, case 42. The operations here reported were done for removal of ovarian tumors and pathological conditions associated with the ovaries and uterine appendages. It is true that some of the cases were simple tubercular peritonitis, in which the appendages were not removed, but the history of the case, in each instance, and direct physical examination, gave some little question as to whether there might not be an ovarian complication with the suspected tubercular trouble.

I realize that my work is far from being as successful as I could have wished, and yet, in a personal, critical retrospection of the causes of death, I feel that I have gathered an experience that will be to the benefit of my future patients, and I trust somewhat to those of my associates and successors who may continue to do this line of work.

CASE 1. Mrs. C. C., duration disease two years; history of several attacks localized peritonitis, accompanied by vomiting.

Operation February 20, 1888, revealed multilocular ovarian cyst, papillomatous in character; some adhesions; broad pedicle; Tait knot. Patient did well for forty-eight hours, then began to vomit, showing marked evidence of intestinal obstruction, which continued unrelieved. Died on third day. Autopsy revealed obstruction due to loop of small intestine having attached itself to stump of pedicle.

CASE 3. Mrs. F. C., operation April 9, 1888, revealed multilocular ovarian cyst, with sarcoma of mesentery—latter ligated separately and removed. Uterine appendages also removed. Drainage. Patient in good condition of health six months after operation.

CASE 4. Miss C. D., maternal grandmother died of cancer. Menstruated at fourteen; scanty and painful; severe amenorrhœa and dysmenorrhœa since. Four years previous, after a severe fall and cold, had pelvic peritonitis. Leucorrhœa always very severe. Suffered from general pelvic pain, and unable to perform household duties, much of the time being a confirmed invalid. Operation May 31, 1888, showed adhesions quite marked, right ovary enlarged, and tube much thickened, left ovary undergoing cystic degeneration, tube not so much diseased as right one. Stitch-hole abscess on sixth day. Finally good union, patient discharged on twenty-fourth day after operation.

CASE 6. Mrs. A. M., mother, two paternal and two maternal aunts died of phthisis; maternal cousin had abdominal tumor. Personal history very good. Married at sixteen; two children; one miscarriage; youngest child twenty-eight years old. Seven years previous to operation noticed some trouble in left iliac region; dull pain, and soon after side

began to enlarge. Five years later menstrual periods became irregular, and later still legs became œdematous. Examination urine showed no disease of kidneys. Abdomen measured forty-two inches in circumference about umbilicus. Operation May 31, 1888. No adhesions. Weight of cyst and fluid thirty-five pounds. Patient in much pain after operation, and given one-quarter grain morphia, hypodermatically, every six hours for first day, after which it was discontinued. Bowels moved second day; superficial stitches removed fourth day; deep ones fifth day; wound healed by primary union. Without any assignable cause temperature third day rose to 102½°, within few hours returning to nearly normal, after which patient made uninterrupted recovery, and discharged on twenty-third day.

CASE 7. Mrs. A. O'C., family history good. Never had severe illness; menstruated at twelve, which was and always has been painful, but normal in quantity and general appearance. During September, 1887, first noticed pain and tenderness in right iliac region. Pain dull, burning variety, and seemed to extend gradually upwards. Four months later noticed enlargement left side, gradually increasing in size, patient measuring thirty-four inches in circumference. Two weeks previous to operation had severe, paroxysmal pain in left inguinal region, especially severe upon deep inspiration—continuing for ten days. Menstrual periods regular during growth of tumor and less painful than before. Bowels habitually constipated, except two weeks previous to operation. Operation May 31, 1888, revealed large, multilocular ovarian cyst, connected with left ovary and tube, having many adhesions to bladder and intestines, which were relieved without great difficulty by means of pressure of hot sponge, proving them to be of recent origin, probably outgrowth of recent peritonitis. To deliver cyst required breaking up of very many smaller cysts through original opening in larger cyst. Right ovary undergoing cystic degeneration and removed. Abdomen thoroughly flushed with hot water. Weight cyst and fluid twenty pounds. Fluid thick and gelatinous, and portions escaping into abdominal cavity made irrigation necessary. Patient given few hypodermic injections of morphia first twenty-four hours to relieve pain. Superficial stitches removed third day, deep on fifth, wound thoroughly healed. Evening eighth day, after evacuation bowels, patient had severe chill, followed by temperature 102°, with profuse sweating. No abdominal tenderness, but hard, indurated mass could be felt about lower end incision. Warm applications used, and five-grain doses quinine given every four hours. On evening of tenth day about one ounce of black, tarry, fœtid substance discharged per vaginam, vaginal douches being used after that each day. Temperature fluctuated between 102° and 104⅘° for thirty-six hours, but decreased on eleventh day, and on twelfth normal—

no suppuration of wound. Indurated mass in region incision entirely disappeared, and from this time on patient made an uninterrupted recovery, being discharged on twenty-fourth day.

CASE 8. Mrs. P. A. R., paternal grandfather died of cancer; paternal aunt of phthisis pulmonalis, otherwise family history good. Menstruated at thirteen, regular up to fifty-two, except during pregnancy and when nursing children. Two children; two miscarriages. Patient first noticed small enlargement left side abdomen two years previous to operation, painless and increased in size very slowly until April, 1888, when it grew rapidly and became somewhat painful; much inconvenience in getting about; circumference at navel forty-one and one-half inches. Operation July 5, 1888, revealed double ovarian cyst; right nearly unilocular, tapped, removed without much difficulty, although some adhesions to intestines. Cyst left ovary adherent to omentum, giving rise to considerable hæmorrhage, requiring several ligatures; weight, cysts and fluid, forty-two pounds. Patient had quite severe mitral stenosis, but bore anæsthetic very well. Stitches removed fifth day; patient made good recovery and discharged on twenty-first day.

CASE 9. Miss E. B., family history very good. Patient suffered many attacks of pelvic peritonitis. Operation October 1, 1888, revealed double pyosalpinx; many and firm adhesions; operation very difficult; removal uterine appendages. Good recovery. Two years later patient died from what, at that time, was supposed to be sarcoma of cavity of pelvis.

CASE 10. Miss M. W., æt. 20, good family history. Unilocular cyst; uncompleted operation. After operation no symptoms presented to cause anxiety, except as to pulse rate, not going below 100, tenth day increasing in frequency, and patient showed a nervous, agitated state, although bowels had moved properly, etc., but she gradually sank and died on fourteenth day. Autopsy revealed large number of clots in pelvis, same condition had extended up into abdominal cavity, particularly in right lumbar region, clots undergoing septic change, but no pus present; ligature was found loosened and discovered to have come from stock of imperfectly prepared silk, none of it being used afterwards. In this case I believe had there been no internal hæmorrhage, or, when it presented, had I opened up, washed out, thoroughly controlled bleeding vessels and drained, she might have recovered; yet at no time was there shock enough to indicate this procedure warrantable.

CASE 11. Mrs. C. W., family history of phthisis. No children; one miscarriage, 1880. Regular menstruation until August 4, 1888, when it ceased. May, 1888, after hard day's work, taken with severe pain, crest right ilium, lasting fifteen hours; enlargement presented afterward. Diagnosis of ovarian tumor; tumor enlarged rapidly—tapped October, 1888;

patient afterward suffered from occasional attacks biliary colic and swelling of right leg. Operation, November 19, 1888, revealed large multilocular cyst, from left ovary, containing variety of colored fluids, ranging from light to dark, dirty greenish appearance. Cyst contained papillomatous growth; right ovary healthy, not removed. Operation protracted, as hard, solid portions of tumor rested over right kidney and iliac vessels, undoubtedly from pressure, causing swelling of leg on that side; drainage for about forty-eight hours. Excellent recovery, and patient discharged twenty-second day.

CASE 12. Mrs. H. T. T., family history decidedly cancerous. Four children; one miscarriage, seventh month. Menstruation normal. After birth second child, solid tumor, size of cocoanut, developed in left lumbar region, disappeared under treatment, appearing again at birth of third child, disappearing after delivery; patient at this time very ill; constant vomiting for a week, with suppression of urine; however, made very good recovery. No trouble fourth pregnancy; at fifth, had post-partum hæmorrhage. Three years previous to operation began to enlarge slowly for eight months, when on rising one morning growth had disappeared, doing this several times since. About that time tapped twice, at intervals of a week. Operation, December 21, 1888, revealed tumor springing from left ovary, cyst holding twelve quarts of fluid. Many adhesions. Operation difficult. Several silk ligatures applied within abdominal cavity. Right ovary also removed. Uninterrupted recovery, discharged on twentieth day.

CASE 13. Mrs. H. M. R., family history of phthisis. Six years previous to operation delivered of stillborn child. Health not good since. Menstruation regular, but always painful. Took fifteen to twenty grains chloral nightly. Three years previous to operation treated fifteen weeks by Dr. Emmett, in Woman's Hospital, for ovarian trouble and ante-version. After return home husband continued use of tampons, cotton, and glycerine, but no improvement, and patient confined to bed four months. Diagnosis, double salpingitis, confirmed by operation December 22, 1888. Some vomiting and continued pain in back after operation, otherwise good recovery, and discharged thirtieth day.

CASE 15. Mrs. N. M., family history good. Menstruation normal. One child, three years old; one miscarriage. First noticed distension of abdomen one year previous to operation, and was treated for ovarian dropsy and lung trouble by Dr. Woodward, of Vermont, for some time. Operation revealed ascitic fluid, peritoneum studded with small papillæ, giving somewhat the appearance of warts on a toad's back. Condition concluded to be one of tubercular peritonitis. Right ovary enlarged and removed. Masses afterwards proved to be tubercular in character. Glass drainage, which gave her much discomfort, was removed on fourth day and

replaced by soft rubber tube. This removed on twelfth day, drainage having ceased entirely. Patient made an uninterrupted recovery and remained in good condition afterwards. One point of interest presented in her case, *i.e.*, regarding glass drainage tube not being turned and raised each day by the nurse, its becoming quite firmly attached in position and removed with some difficulty. Patient discharged on twentieth day.

CASE 16. Miss I. R., æt. 26. Family history only fairly good. Suffered from dysmenorrhœa, and severe, well-marked attacks pelvic peritonitis. Feeble and emaciated when I saw her with family physician, with great effort continuing her work, that of bookkeeper in large store. Had continued indigestion with vomiting. Case evidently one of salpingitis, and probably double pyosalpinx. Cœliotomy April 5, 1889. Many firm adhesions, difficult to separate, but removal appendages completed. Pelvis left in good dry condition. Patient vomited from time of operation, at last a spinach-like substance. No distension abdomen; bowels moved safely, no symptoms obstruction, but patient died from inanition on eleventh day. Autopsy showed evidence general peritonitis. Careful going over of technique of operation and surroundings failed to show any evidence of error.

CASE 19. Mrs. F. W., family history good. Menstruated at fourteen; married at fifteen; fourteen months later delivered of living child at seventh month; premature delivery caused by boy jumping on abdomen; second delivery normal and child still living; one miscarriage since at third month; menopause at forty-eight. October, 1888, operated on by Dr. Boyd for prolapse of uterus; no evidence of tumor at that time; thinks growth since to have been occasioned by resting filled coal scuttle upon left ovary at times for past six years. December, 1888, observed aching pain in this region; some bloating, and felt ill all winter; blisters and hot applications used; first noticed enlargement, size of goose egg, in February, 1889; examination in May gave all the symptoms of ovarian cyst. Operation June 15, 1889; diagnosis confirmed; cyst removed; quite a number of adhesions; drainage; recovery, followed by hernia some six months afterwards.

CASE 20. Mrs. B.A., æt. 22, family history of phthisis. Met with injury May, 1888; following October abdomen enlarged; tapped April 18, 1889, fifty pounds of fluid drawn; circumference at umbilicus, forty-four inches; though desperately ill, yet she and her friends were very anxious for an operation. Cœliotomy August 22, 1889; time required, one hour and thirteen minutes; very extensive and firm adhesions of sac to peritoneum; much hæmorrhage; multilocular cyst, left ovary removed; right ovary enlarged, with evidence of another cyst developing, also removed; glass drainage; every effort made to bring patient out from condition of shock,

but she died at 4 p.m., August 30. Autopsy revealed no hæmorrhage within peritoneal cavity. Case probably hopeless from beginning, and illustrates the seriousness of delay and evil results of tapping.

CASE 21. Mrs. E. B., widow, aunt died of cancer of tongue, otherwise history good. Menstruated at sixteen; regular, without pain; married at seventeen; three children; two miscarriages; menopause at forty. One year previous to operation abdomen began to enlarge, and gave some distress on motion. January, 1889, could feel good-sized tumor in left side, which she could steady with hand when turning in bed. March, 1889, tumor tapped, but no fluid withdrawn. Six weeks previous to operation tumor grew more rapidly. Twelve days before operation Dr. Fuller aspirated left side and drew off small quantity of what seemed to be purulent fluid. Weighed 135 pounds year before operation. Emaciated, anæmic, bowels regular, appetite very good, urine scanty, pulse 128, temperature 99°, measured 47 inches about navel. Diagnosis, multilocular ovarian cyst. Operation September 23, 1889; diagnosis confirmed; scarcely any adhesions; large cyst filled with colloid material; ovaries removed; drainage; patient making good recovery.

CASE 22. Mrs. C. L., family history of phthisis; mother of three children; one miscarriage; strong and healthy as a girl; menopause at forty-five. March, 1889, after very hard work, noticed enlargement left side abdomen; filled rapidly and tapped in July; one-half gallon fluid removed; tapped again August 16, nearly same amount fluid. First tapping fluid had bloody appearance, second purulent. Had attack of what was called bilious vomiting September 28. Appetite good, bowels inclined to diarrhœa; legs enormously swollen, at times discharging serum. Operation October 14, 1889; adhesions of sac to peritoneum very decided. When trocar was introduced there escaped a greenish-looking fluid. Introduction of hand into opening of sac became necessary, and a material looking like custard or omelette was scooped out; sac carefully separated from peritoneum, such vessels ligated as became necessary, peritoneal cavity irrigated with hot water, drainage tube inserted, and incision closed; patient vomited almost constantly for first forty-eight hours, finally ceased; drainage quite free, glass tube removed end fifth day, rubber substituted, left in but few days longer; patient made excellent recovery.

CASE 24. Mrs. M. B., patient has three living children, youngest eleven years old. Menstruation regular from fourteen up to forty-three, when she flowed every two or three weeks. In December, 1888, first noticed slight enlargement on left side; during last six months has enlarged more rapidly, pelvic cavity free from deposits; uterus freely movable. Operation October 29, 1889; ovarian cyst tapped and mucilaginous dark-

colored fluid drawn off. Several adhesions found on left side; as sac was drawn out it was found to be multilocular; sac lifted out *en masse* and small pedicle ligated; patient recovered rapidly.

CASE 25. Mrs. R. H., family history good. Menstruated at fourteen; two children, no miscarriages; youngest child ten and oldest eighteen years old; since birth of first child suffered from pelvic pain, especially severe at menstrual epoch; pain feels as if bands were being tightened around the intestines. Not free from pain for eighteen years. Operation March 4, 1889, showed both ovaries bound down by strong adhesions; nothing further done than to loosen adhesions as much as possible; impossible to isolate ovaries; abdominal wound sutured in usual manner, glass drainage; patient made good recovery.

CASE 27. Mrs. D. S., mistaken diagnosis; supposed large ovarian cyst. Cœliotomy November 14, 1889, revealed tubercular peritonitis; ascites; one ovary removed; improved; patient died later on of return of peritoneal dropsy.

CASE 28. Mrs. S. N., menstruated at eleven. Not regular. Flow would cease for seven weeks or two months. Has five children. Three miscarriages. Youngest child three years old. Two years ago noticed enlargement in right ovarian region. April, 1889, began to flow excessively, and on one occasion flowed steadily for two months. Enlargement gradually increased. Operation December 5, 1889. Ovarian tumor. Chill on fourth day, controlled by quinine. Cyst fluid twenty-two pounds. Uninterrupted recovery.

CASE 29. Mrs. H. N., family history good; delicate as a girl. Menstruated at twelve; dysmenorrhœa always; three children; no miscarriages. Flowed excessively at times, more since marriage; suffered every month during pregnancy. Since birth last child—two and a half years old—pain more or less daily, sharp, stabbing, radiating from ovarian regions, down thighs, and through back. Bowels regular; appetite good. Operation January 27, 1890. Left ovary, with tube, enlarged and removed. Right also removed. No drainage. Vomited once after operation. With exception of sharp pain and nausea, no untoward symptoms. Stitches removed on fourth day; no suppuration. Partook regular diet fourth day. Uneventful recovery.

CASE 30. Mrs. A. McK., first trouble two years ago, thrown from carriage, followed by constant pain in dorsal, lumbar, and sacral regions. Urination painful. Inflammation of uterus diagnosed. Severe pain in pelvis and hip. Confined to bed. Improved somewhat, but unable to walk. Recurrence of trouble in August. Physician diagnosticated cystitis, and washed out bladder, but attended with such severe pain, discontinued. Improved sufficiently to be brought to hospital December 2

1880. Galvanism applied; pain decreased somewhat, but back so sensitive, current discontinued. First menstruated at thirteen; exposed to cold shortly before second menstrual epoch due, and flow absent one year. On return, so painful, often confined to bed. Between August 4 and December 9, flow absent. Paroxysms of pain at time when flow would have naturally appeared. Since December, up to date, nothing appeared. Laparotomy and double oophorectomy, February 23, 1890. Extensive adhesions of ovaries and tubes; small cyst on right side. Patient did well; received two hypodermics of morphia up to Friday night, when was taken with severe attack resembling hysteria; husband had been visiting patient; did not rally for several days, and kept under the influence of morphia at times. After this recovery uneventful. Stitches removed March 5th.

CASE 31. Mrs. E. H., always delicate as a child. Menstruated at twenty. Monthly pains previously, but no flow. Menstruation painful, patient having to go to bed. Flow sometimes lasted ten days, at times occurring every three weeks. Two living children; seven or eight miscarriages. First child born at seventh month. Second at full term, but labor difficult—instrumental. All miscarriages occurred after this labor, and all without any known cause. Patient treated for some uterine trouble for past twelve years; in 1889, fell on sidewalk, hurting left side quite badly; after fall, lost flesh rapidly, eighteen pounds in one month; before this, felt quite well; one month later, noticed enlargement in left ovarian region, about size of an orange; painful for about two months, then pain ceased for a time, but is now present; growth not rapid; at times sensation like fluid moving from side to side of tumor when in bed. Operation for ovarian cyst performed April 22, 1890. Cyst removed; drainage; recovery.

CASE 32. Mrs. J. V., cœliotomy, April 30, 1890. Multilocular ovarian cyst; previous peritonitis; removal of cyst and both ovaries. The adhesions in this case were so severe that, on separating them with wet sponge and fingers, the hæmorrhage was quite constant and considerable. Several vessels in omentum and abdominal walls were tied with silk. The abdominal walls, owing to the great size of tumor, were, after the operation, very lax, and admitted of being folded over on themselves afterward; peritoneal surface sutured with deep sutures to control hæmorrhage, and which had a good effect. These sutures were removed after forty-eight hours; sponge lost in cavity; found after prolonged search; drainage. Recovery.

CASE 34. Mrs. E. C. Father died of heart disease; otherwise family history good. Patient had scarlet fever when a child, leaving her with some kidney trouble. Menstruated at twelve; first child born nine years

previous to operation; delivered of five children; last, she thinks, at eight months, living only one week. Since birth of third child, noticed irregularity in menstrual flow; more frequent and profuse. Lessened, however, two or three months prior to operation. September, 1889, patient tapped for supposed ascites; four gallons removed. January, 1890, again tapped; quart of fluid obtained. Pregnant, at time, with last child. End of February, 1890, tapped again; amount of fluid only a few quarts. Fourth and last tapping, August, 1890; three gallons of fluid. Child born between third and fourth tapping (March, 1890). Punctures for tapping, one, two, four, in linea alba; three almost in right hypochondrium. August, 1890, patient noticed enlargement in right inguinal region, but noticed distension early as birth of third child, disappearing for a time, then reappearing. Treated, at time, for ovaritis and enlargement of uterus; temporary relief. Enlargement in left side, but different from other. Leucorrhœa since birth of first child. Abdominal section September 22, 1890. Multilocular ovarian cyst, right side; left side, parovarian cyst; no adhesions; patient troubled with catarrhal inflammation of intestines, which kept up diarrhœa for some time. Course of recovery uneventful, and otherwise uninterrupted.

CASES 35 and 59 constitute the same patient, Miss L. McC., æt. 23. Menstruation painful; vomiting at times. Injured, and treated a long time for spinal trouble, also retroverted uterus. Slipped on ice, and afterward vomited for four weeks. Alexander operation for relief of retroversion, March, 1889, by Dr. Pilcher, of Brooklyn. Menstruation more painful after operation. Entered Albany hospital, April, 1890. Uterus carefully curetted, after rapid dilatation; no improvement. Cœliotomy October 7, 1890. Right ovary enlarged to size of turkey's egg; tube much thickened; both removed. Left ovary and tube apparently healthy; not disturbed. Recovery uneventful; discharged November 3, 1890. No permanent relief from operation. Various kinds of treatment tried without benefit. Second cœliotomy, November 9, 1891. Left ovary, size of small orange, undergoing cystic degeneration; tube enlarged; both removed. Good recovery; patient in excellent health September 1, 1894.

CASE 36. Miss M. G. Mother died of pneumonia, otherwise family history good. Health never good; menstruated at thirteen; first day of flow always accompanied by dysmenorrhœa, lasting five days; fluid dark and liquid. About four years ago patient noticed enlargement in abdomen; does not remember where it began. Gradually increased until tumor began to interfere with respiration, when, fluid being suspected, patient tapped, February, 1880. Ten quarts removed, but necessary to tap again in August, 1889, four quarts being obtained this time. Both punctures low down and in linea alba. Never any pain about loca-

tion of punctures. Since last tapping, abdomen enlarged until about as large as first tapping. Operation October 10, 1890. One large and several small cysts removed; some very slight adhesions broken. Left ovary healthy; not removed. Recovery uninterrupted. Apposition at lower angle not perfect; silkworm gut; exuberant granulations.

CASE 37. Mrs. E. W. Family history good; personal history good until two years previous to operation; menstruated at thirteen; married eight years; has two children; two miscarriages; oldest child five and youngest two years old; first miscarriage, April, 1888; second, September, 1888. Cause of first, fall; second, indefinite; both supposed to have been advanced to third month. In the summer of 1889 patient had pain over the site of right ovary, which grew steadily worse until, in November, she was forced to her bed for some time. Blisters and hot applications had no effect. During winter had attacks of unconsciousness. Operation, October 21, 1890, revealed enlargement of tube and ovary on right side, due to chronic inflammation. Left ovary could not be found; apparently thoroughly atrophied, and covered by firm adhesions. Right ovary and tube removed in usual manner, after tearing away numerous adhesions. Glass drainage, packed with iodoform gauze. Drainage very bloody for some time; gradually cleared. Glass tube removed October 24. Rubber tube substituted; removed 27th. Further course uneventful. Discharged the sixteenth day.

CASE 38. Mrs. S. K., four years previous to operation had severe brownish-looking, offensive discharge from vagina. Steady pain in ovarian and across lumbar regions. Husband admitted having had specific urethritis. Diagnosis, pyosalpinx. Cœliotomy, October 30, 1890. Bilateral pyosalpinx, double parovarian cyst and small fibroid, size English walnut, on fundus uterus. Uterine appendages removed, then fibroid. Latter carefully dissected from fundus, but bleeding very severe, controlled by use of thermocautery. Glass drainage; discharge free for forty-eight hours; rubber tube substituted and kept in for five days. Recovery uneventful; discharged eighteenth day. Eight weeks after operation small abscess formed in sinus left by drainage tube, through which escaped one of the silk ligatures.

CASE 39. Mrs. F. M., menstruated at thirteen—had a severe fall at same time; sick two weeks from this—perfectly helpless; two years after ill again in the same way—did not leave room for three years. Ever since menstruating pain in back—much increased during first two or three days of monthly periods. Married ten years; one child; no miscarriages. Diagnosis of ovarian trouble made. Oophorectomy November 29, 1890, left ovary cirrhotic, right in condition fibro-cystic degeneration; both removed. Day following operation severe pain over spine of right scapula—darting

down back of arm even to tips of fingers; joints tender for some time; this lasted for three days, recurring at intervals afterwards in spite of counter-irritants and galvanism; third day usual attempt was made to move the bowels with enema, without success; was continued during the whole week, sulphate of magnesia and one sixth grain calomel administered without any result until seventh day, when small movement. December 9, bowels moving daily. Cystitis with frequent desire to urinate was an annoying complication; her symptoms finally improved, she leaving the hospital January 5, 1891; patient, from letters received later, made a slow but good recovery,

CASE 41. Miss E. K., æt. 33. Abdominal trouble at eleven, diagnosed as dropsical, which disappeared under treatment; multiple abscesses about left leg; Dr. A. March operated, removing necrosed portions of bone; later, old cicatrices opened up partially. March, 1890, felt sharp sudden pain in each groin, after lifting heavy washing; enlargement on both sides, corresponding to double femoral hernia, followed, abdomen now enlarged. Operation advised, but advice not followed, patient enlarging rapidly in meantime. I advised operation December, 1890. Cœliotomy January 3, 1891; cyst of right ovary had ruptured. Multilocular cyst, left ovary, with uterine appendages, removed; both cysts contained viscid, glairy mass, some remaining and being agglutinated to intestine; thorough irrigation; drainage—removed third day; severe diarrhœa controlled; tenth day lower angle wound opened, discharging four to five ounces fœtid pus, after which patient made good recovery, discharged April 29, fistula almost healed.

CASE 42. Miss M. G., family history good, with exception of one uncle dying of phthisis. Personal health good up to 1889, when patient had attack of anæmia; recovered wholly from this. Menstruation at twelve, painful but regular. Noticed hard enlargement abdomen in 1890; growth slow at first, but during two months previous to operation rapid. Diagnosis, tubercular peritonitis. Cœliotomy January 14, 1891. Profuse discharge of fluid; peritoneum studded with tubercles; left ovary enlarged, cystic and studded with tubercles—removed; glass drainage, removed thirteenth day, rubber substituted; discharge gradually lessened, at end of second week; drainage tube forced out, could not be reinserted; gauze packing for ten days; discharged forty-second day, recovery complete—no ascites.

CASE 43. Miss J. S., æt. 19, family and personal history good. Tumor developed fifteen months previous to entering Albany hospital, February 27, 1891. Diagnosis, unilocular cyst. Cœliotomy February 28, 1891, 11 a.m. Unilocular cyst from left ovary found, two gallons clear-looking fluid removed, and pedicle secured with Staffordshire knot; cyst,

size of ordinary walnut; surface of right ovary opened and curetted; edges of this incision sutured with iron-dyed silk; ovary and tube returned to pelvic cavity. Saw patient at 1 p.m., when all seemed to be going well; was called out of town, not returning until 7.30 p.m., when, on visiting patient with house physician, internal hæmorrhage was evidently going on. Pulse 142, and sighing respiration; wound immediately reopened, pelvis and abdominal cavity found filled with clotted blood; vessels had slipped from ligature, or knot loosened, evidently within an hour previous, from record of nurse. Pedicle religated; no hæmorrhage from incision in right ovary; two pints saline solution poured into the peritoneal cavity, wound closed and drainage introduced. Everything possible to bring on reaction was done; patient rallied slightly at first, and it seemed possible for her to react, but her mental condition was seriously shocked; she was alarmed, gradually sank, and died March 1, at 8.10 p.m.

CASE 44. Mrs. A. E., family and personal history good. Rapid enlargement right side near spine of ilium from December, 1890; solid growth left side. Cœliotomy, March 3, 1891. Papillomatous cyst from left ovary; three gallons of fluid, some adhesions; another cyst connected with right ovary, closely adherent to surrounding tissues; this tapped and emptied of a viscid fluid—dirty, brownish color; in bottom of this cyst was another papillomatous growth; adhesions such it was impossible to remove this entire, cyst walls stitched to abdominal wound, and rubber drainage introduced; left side, pelvic cavity, glass drainage tube placed; patient recovered quickly and discharged May 18, 1891; slight sinus of cyst, right side, still existed. Readmitted June 3, 1891, with partial obstruction of bowels. Yielded to calomel, salines, and enemas; sinus closed, but showed disposition to open, and mass could be felt connected with right side of pelvis; improved slowly, and finally discharged August 12, 1891, having gained in flesh and strength. In good health until January, 1893, when there was a return of intestinal obstruction, and patient readmitted to hospital. Great distension of abdomen; lower portion old cicatrix incised; immediate presentation old, papillomatous mass filling right side pelvis. In attempting to enucleate mass, small intestine was opened into; gauze packing introduced, supposing that patient could scarcely recover, but by continuous irrigation a great amount of detritis washed out, finally fæcal fistula closed, patient had normal movements, gained in health and returned to her work, but during latter part of winter of 1894 growth had increased, and in May she suffered from a fistulous opening connected with sarcomatous mass, giving off an offensive discharge. Not heard from since.

CASE 45. Mrs. N. A., family history tubercular maternal side, good otherwise; personal history anæmia, but fairly well nourished. Two chil-

dren, youngest five; no miscarriages. After birth last child, pain developed right side over ovary. 1890, first noticed growth in right side, which gradually increased; menstrual flow normal and regular until five months previous to operation, then more profuse, and dull pain followed advent, in right side; feeling of numbness in right leg since birth last child. Operation March 18, 1891. Removal both ovaries, left adherent. Tumor felt right side proved to be an ectopic pregnancy. Bowels moved third day, stitches removed eighth; on twelfth patient sat up for one hour and walked about ten feet; made splendid recovery and discharged on seventh day. Later, patient had her menstrual period for over a year. I then curetted cavity uterus thoroughly. Since which time she has remained well.

CASE 46. Mrs. M. S., cœliotomy April 25, 1891. Multilocular ovarian cyst, left side; right ovary undisturbed; there were some adhesions; glass drainage for five days, then rubber—after removal discharge, at times pus, continued for six months, when ligature came away and patient made a good recovery.

CASE 47. Mrs. E. C., father died of phthisis at thirty-four; mother living at fifty-six, and has had cerebral hæmorrhage. Menstruated at fourteen; ceased for year, regular since; one child, aged six; no miscarriages. Since birth of child menstruation very painful; peritonitis after birth of child, again in 1883, brought on by lifting; typhoid fever at seventeen; pneumonia at twenty; in 1889 had cough and slight hæmorrhage from lungs. Occipital headache; appetite poor; urine normal. Cœliotomy, May 4, 1891. Oophorectomy; both ovaries cirrhotic—left cystic—bound down by firm adhesions; tube packed every ten minutes with gauze for three hours; removed May 5, much pain until tube removed; no noticeable improvement until eighth day, when enema given was followed by very free movement of gas and fæces. Recovery uninterrupted except for obstinate cystitis, present still when discharged on thirty-fifth day.

CASE 48. Mrs. A. McC., family history good. Menstruated at twelve, painful; fifteen years previous to operation trouble began, accompanied by spasms. Second child born, 1883; two years later diagnosis of uterine misplacement made and she received treatment. Pain in right ovary for ten years, along spine painful points, occasional points pain along angle ribs, sternum on left at juncture true and false ribs. All treatment failed, and cœliotomy done May 22, 1891. Both ovaries diseased; right markedly cirrhotic; salpingitis. Improved rapidly and discharged twelfth day. Readmitted to hospital September 24, 1891, very hypochondriacal—no special treatment, and patient left much improved, October 12, 1891. March, 1892, much improved mentally and physically.

CASE 49. Mrs. E. C., aged thirty-three, family history good. Suffered from dysmenorrhœa; at twenty had peritonitis; married at twenty-one;

first child one year after; labor very difficult; dysmenorrhœa ceased after that; since birth of child has had dull aching pain, both sides ovarian regions. Treated fall of 1890 for stricture of rectum and lacerated cervix; no improvement; mass size large orange left side of pelvis. Diagnosis of salpingitis, operation advised. Cœliotomy May 27, 1891. Both ovaries enlarged, cystic, double pyosalpinx; appendages removed; many firm adhesions; glass drainage tube—rubber substituted third day, serious discharge still quite free; drainage removed seventh day; some pain over abdomen, otherwise recovery uninterrupted. Discharged on twenty-first day; in perfect condition of health September, 1894; gained in flesh and strength; able to get about with absolute comfort.

CASE 51. Miss L. M., invalid many years, vague trouble. Physician supposed it chronic case hysteria, but first examination revealed enlarged inflamed ovary right side; extremely irritable descending colon; well-marked myelitis lumbar region; extremely anæmic, errotic, sleepless, plaster jacket applied for artificial support, later Paquelin in cautery, down spine, excellent line of treatment tried with only temporary relief; menstruation irregular, scanty, painful. Diagnosis cirrhotic ovary double salpingitis. Oöphorectomy July 13, 1891. Diagnosis confirmed, also pyosalpinx left side. Patient did nicely with exception of nausea for few days; stitches removed fifth day; recovery uneventful, and discharged August 15, 1891. Letters from Dr. Church and patient later report good result.

CASE 52. Mrs. A. E. B., family history good. Well during childhood; menstruated at thirteen; delicate until twenty; one miscarriage. Periods not painful, but flow profuse. Well until eight weeks previous to operation. May, 1891, noticed enlargement abdomen, supposed due to gain in flesh. October, 1890, to June, 1891, flowed constantly, but small in quantity. No show since June, 1891. July, 1891, sudden, severe pain left side abdomen; diffuse and general peritonitis developed, lasting four weeks. Cœliotomy, September 1, 1891. Large ovarian cyst, left side. Both ovaries removed. Patient very weak during progress operation; hypodermics of brandy and strychnine given. Drainage tube removed second day; bowels moved fifth day. Good recovery. Discharged nineteenth day.

CASE 53. Mrs. M. M., family history negative; patient generally well; menstruated at fifteen; always regular—dysmenorrhœa. In 1879 had inflammation of bowels. One miscarriage first year of marriage. Six months previous to operation noticed enlargement left inguinal region: increased rapidly, distending whole abdomen. Slight dyspnœa. Cœliotomy, October 1, 1891. Ovarian cyst, left side, two gallons fluid. Pedicle of sac from left broad ligament—ligated in sections and removed, also tube and ovary, that side—cyst and hydrosalpinx. Patient rallied well

from operation; troubled with nausea and vomiting two or three days. Sat up eleventh day; home fourteenth day, feeling very well. In good health one year later.

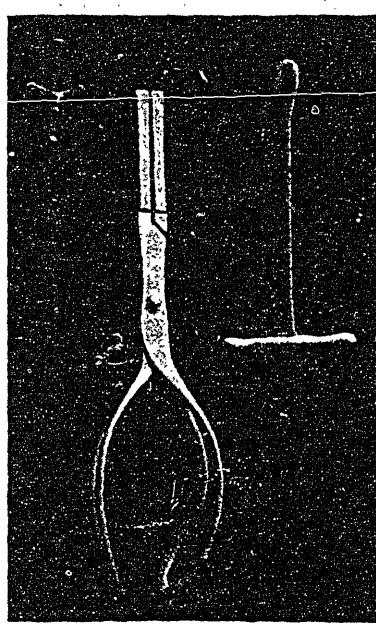
CASE 54. Mrs. V. S., family history of paralysis; menstruated at fourteen, when she took cold; afterwards suffered from dysmenorrhœa; married at twenty-one; no children; no miscarriages. Thirteen or fourteen years previous to operation, tumor in right hypochondrium—contents evacuated, she said, through stomach. Sick nine years. Spinal trouble prevented walking for six months. Misplacement of uterus. October, 1890, tumor in inguinal region—grew rapidly afterwards; in June, 1891, distending whole abdomen. Menopause at fifty-two; cœliotomy, October 6, 1891; short incision, large unilocular ovarian cyst, right side; six quarts fluid removed; cyst removed. Patient did nicely; bowels moved third day; discharged seventeenth day; in good health two years after operation.

(*To be continued.*)

OBSTETRIC FORCEPS.

By K. N. Fenwick, M.A., M.D.,
Professor of Obstetrics. Queen's University,
Kingston.

EVERY practitioner has a fancy for some particular variety of forceps, but perhaps has no good reason for his choice, other than that it is the instrument he first became used to, or that it was recommended by his teacher, and so he has continued to employ it.



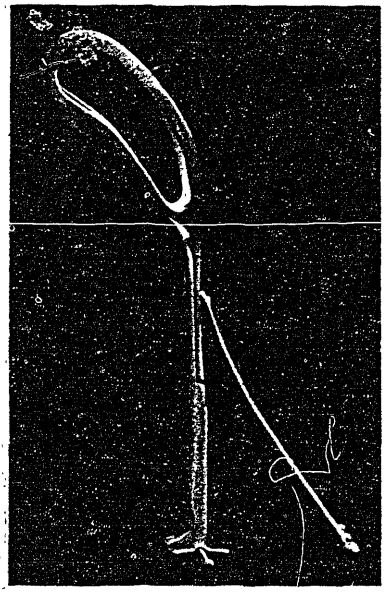
As a rule, a long pair of forceps suits one's purpose both at the outlet and in the excavation, and by certain appliances or manœuvres it can also be used as an axis-traction instrument when the head has just engaged at the brim.

Having felt the need for some time of a forceps which would meet all indications, I had a pair made, which have done me good service, and

which I brought before the last meeting of the Dominion Medical Association at St. John, N.B.

All forceps may be divided into two classes—those constructed upon the English type, the best examples being Simpson's, Barnes', and Elliott's, which are intended to be applied to the sides of the pelvis, but do not exercise compression; and those constructed on the French type, the Hodge being a good example, and are intended to be applied to the sides of the child's head.

The French type seems to me more scientific, as we can exercise a slight amount of compression when necessary, and assist rotation when the head is high up in the excavation.



Then, by the use of the traction rod, the tendency to the use of the "oscillatory movement" is done away with, so dangerous to the child and the soft parts of the mother, while the child's head is thus drawn through the whole length of the pelvic canal in its proper axis, with the least expenditure of force.

It is very obvious that the ordinary forceps cannot accomplish this, as it makes traction only in one direction, and hence much of the force is expended on the pubic bone or tissues of the mother, instead of the child's head.

Furthermore, as the child's head is flexed on its chest, the ordinary

forceps are apt to grasp the head too near the sinciput, and so undo flexion, substituting the occipito-frontal for the suboccipito-bregmatic diameter.

Again, to avoid slipping, the German lock is much better than the English or mortice lock, and this is fortified by a screw at the end of the handles, which also can be used to produce compression when that is necessary.

This screw is removable, so as to be easily cleaned.

To render the instrument thoroughly aseptic, it is made entirely of metal, so that it can be boiled before using.

To recapitulate, then, the instrument here figured is constructed of the best steel only, and nickel-plated, so as to be aseptic and easily cleaned; the blades are of the French type, the cephalic curve being that of a circle, whose diameter is nine inches; the tips are one inch apart; the pelvic curve is 35°; the greatest width is 2⅝ inches; the lock is that known as Siebold's; there is a screw at the end of the handles to hold the blades together when applied to the head, and to make compression when necessary; and there is a traction rod affixed close to the under surface of the blades, by which traction is made, while the handles act as an indicator of the pelvic axis, but are not used to make traction after the forceps have been applied to the child's head.

We thus have an instrument possessing all the advantages of the Tarnier forceps, and very little more expensive than the ordinary Simpson or Hodge.

Selected Articles.

THE RIGHTS AND PRIVILEGES OF PHYSICIANS CALLED TO CASES OF ABORTION.*

EGBERT H. GRANDIN, M.D., President, in the chair.

The Secretary read the call for the special meeting, signed by twenty members, as follows:

Whereas, a number of instances have occurred in this city where reputable members of this society have been arrested for complicity in malpractice cases, without even the shadow of a reason for such action on the part of the police; therefore, we, the undersigned, respectfully request you to call a special meeting of the society for the purpose of ascertaining the rights and privileges of physicians who may be called to attend cases of abortion, etc.

The President stated that, in the judgment of the members who had signed the call, an indignity had been offered the profession—an indignity which, if not protested against, might become a precedent for the infliction of a similar indignity on each and every physician when, in the pursuit of his vocation, he was called to the bedside of a dying woman. It would seem that the profession was impaled on the prongs of a dilemma which confronted it whichever way it turned. If we did not respond to calls of this nature we were termed, and rightly so, unfeeling, and unworthy the name physician; if we did respond, and on suspicion reported the case to the authorities, if the suspicion proved unfounded, it was a question whether we were not open to a suit for libel; furthermore, if we did report the case and the symptoms supported the suspicion of malpractice, we were liable to arrest and the consequent notoriety. We were here, then, to counsel together calmly, dispassionately, as to our rights and privileges in this matter. The medical profession of this city had always stood on the side of law and order. We were here to protest, in a forcible manner, against the assumption that the presence of a medical man at the bedside of a dying woman was *ipso facto* evidence of wrongdoing, of being

*Being a report of a special meeting of the Medical Society of the County of New York, held March 16th, 1895

an accomplice in a criminal act performed before his advent. We were here possibly also to express again, as we had over and over again, our utter abhorrence as medical men of criminal fœticide. And, while we were about it, we might as well inquire why this crime not only existed, but seemed to be on the increase in this community. The President felt that the statement would pass unchallenged, that a reputable man had never in this city been found guilty of criminal abortion. It was the midwives, and the men under the guise of specialists in diseases of women, the notorious abortionists, who commited this crime, and who were found out, who were indicted, and who were rarely punished. It was proper, therefore, to ask if the blame for the existence of this evil in this city might not properly be laid at the door of the officers of the law. It went without saying, that if swift justice were meted out to these miscreants, the abortionists, they would find this city so hot for them that after a time criminal fœticide would cease to exist in this community, so far as it ever would cease to exist.

The President said Dr. Marx would relate a recent case in this city which would give the members food for thought and discussion.

A Recent Case.—Dr. S. Marx then related the case reported recently in the daily papers. A reputable member of the society had been called to see a young woman, recently a widow, at the house of a midwife. Both parties denied absolutely any form of operation. The patient had ceased to menstruate about four months before, was bleeding, and could give no cause except lifting heavy tubs. Having no other place to go under such circumstances, she had entered the house of the midwife. The doctor made an examination, found the uterus about the usual size at four months pregnancy, filled with detritus, and symptoms of sepsis. The treatment was such as the conditions justified, but as the patient got worse another reputable physician was called, to whom the patient and midwife told the same story, denying criminal procedures. As the physicians were not in a position to remain all night with a dying woman, they advised that a hospital ambulance be called. Notwithstanding that they had complied with the law to the letter, they were taken from their offices by the police to the police court. Before dying, the woman exonerated the doctors and incriminated the midwife. The coroner listened to the story of the detectives, and not that of the physicians, and demanded bail of the latter, which finally was made only nominal. The coroner's inquest showed that the abortion had been committed by the midwife, and that the action of the two physicians connected with the case was simply in line with the duties of their profession, and that they were in no way implicated in the criminal operation.

The President remarked that here was an example, then, where two physicians had been arrested in the performance of their duty, and without

the shadow of a reason. It was true they had been acquitted before the coroner, as might have been predicted, but the story of their arrest had been read in the papers by thousands who thereafter associated them in their minds with abortionists, while the coroner's report probably had not been read by five hundred.

Another Case.—Dr. A. Y. Reid related his own experience with a case of alleged criminal abortion in 1892, a full history of which may be found in the New York *Medical Journal*, April 8, 1893. The points which he emphasized were that any physician was liable to be arrested in the discharge of his duty in connection with cases of abortion, or possible abortion; that there were some men who, under their guise as officers of the law, sought in cases of this kind to incriminate reputable physicians for purposes of blackmail. The coroner in his case laughed at the idea that he would be able to get a jury of reputable physicians, and said he could himself pick out one who would bring in such a verdict as he thought fit. In Dr. Reid's former report of the case we find that the following eminent members of the profession actually served on the coroner's jury: Drs. Munde, Dudley, Boldt, Grandin, Sims, Jacobus, Janvrin, Van Santvoord, Coe, Goffe, Peaslee, and Morrill. Besides absolutely exonerating Dr. Reid, the jury said in its verdict: "This jury desire to express their condemnation of an apparent too great readiness on the part of some persons connected with this case to incriminate, without sufficient evidence, a reputable physician, and thus subject him to the indignity of arrest and criminal prosecution."

A friend afterward heard a police captain say that Dr. Reid would thereafter have to enter the ranks of the abortionists; meaning that legitimate practice would leave him. Such was known to be the usual effect of allowing one's name to enter the newspapers in connection with cases of abortion, however innocent he might be. The result had not been as predicted in this instance; his patients had remained with him, yet there was no doubt but that his practice had suffered considerably, while the legitimate expenses connected with the case had been over $700. He had no doubt but that there were many physicians in the city who were paying blackmail to the police to be permitted to practise their profession legitimately, because some time in the past, when inexperienced, they had begun to do so to prevent their names from entering the public press in connection with some case of abortion with which they had had no criminal, but simply professional, relations.

Dr. John Irwin thought it might be well to exclude the reporters of the press on this occasion, so that members might feel freer in relating their experience. The motion was lost, no affirmative votes.

Physicians not Good Citizens.—Dr. A. Jacobi said he arose to speak, not simply as a physician, but as a citizen of the city of New York. We

all knew what these things meant. These proceedings on the part of the police officers had been of the same character as that noticed in the papers two days ago, where a reputable citizen was held up by an officer in uniform and taken to a police station. The same thing might have occurred to a doctor on his way to see a patient, and he might have handed over five or ten dollars in order not to be detained, or to avoid sleeping in a station. Indeed, he did not doubt but that some present had done that very act, and were now ashamed of it. We had been exposed to robbery of all kinds, and to violence as no city in Europe would permit. And we were all at fault, for we were not good citizens. We had not participated in public affairs. If we would rid ourselves of the danger of being held up in the street, and of being taken from our offices to the station house, we must attend public meetings; must be at the primaries; must go to the polls, not in a body as physicians, but one and all as citizens. As a profession he did not think we could do anything. The common run of politicians cared not what we did so long as we had no votes. Our protest amounted to nothing except at the primaries and the ballot.

Dr. C. A. Von Ramdohr mentioned three cases in which he pronounced the action of coroners or deputy coroners as officious, if indeed it was not based on inefficiency or corruption. He differed from Dr. Jacobi, and believed that the Medical Society of the County of New York could do something. He had once asked a judge of the Supreme Court what he should do in cases of the kind under discussion, and received two replies, one private, the other professional. The first was never to report a case of abortion which might come to his knowledge; the second never to meddle with a coroner's office, nor with the office of a police justice, but to go to the office of the district attorney; it was more decent.

To Obtain Legal Opinion.—Dr. Von Ramdohr then moved that the society obtain legal opinion as to whether doctors had to report cases of abortion which came to their knowledge in the course of their professional duties, to whom must they make the report, and when.

Later this motion was adopted, after having been amended to refer the question to the Comitia Minora and the counsel of the society.

Dr. John A. Irwin contended that it was not for the physician to report to the authorities any case of abortion. For his own part, he declined to play the detective at any time whatsoever. His first and only duty was as a professional man. If called to a patient in distress, he did whatever he could to relieve her, totally ignoring the crime which might have been committed in the first instance which brought on the distress.

Dr. A. Jacobi read a few lines from Field's Medico-Legal Guide, which expressed his own opinion, and was in line with the remarks of Dr. Irwin:

A person duly authorized to practise physic or surgery shall not be allowed to disclose any information which he acquired in attending the patient in a professional capacity which was necessary to enable him to act in that capacity. But the patient may waive the privilege thus secured him by the State, and permit his medical adviser or attendant to disclose such information.

In Dr. Jacobi's opinion, as long as the doctor went to a case of criminal abortion his lips were sealed, and he had nothing whatsoever to do with the police unless the patient waived the privilege of secrecy.

Dr. Bruce made some remarks, and suggested that the counsel of the society ought to defend members in cases of this character, which would be equivalent to a defence by the society. The President replied that the services of the society, through the board of censors, were at the disposal of every member who might happen to be under the charge of criminal abortion of which he was not guilty.

The Coroner's Side.—Dr. E. W. Hoeber spoke from the point of view of the coroner, he having been one elected last fall. He agreed with Dr. Jacobi that it was the fault of physicians that they were in the position of which they complained. They voted for men to fill the office of coroner who were not physicians, and who, therefore, could not be expected to understand so fully the needs, the rights, and the privileges of the medical profession. One speaker had mentioned deputy coroner, there were no deputy coroners, but there were coroners' physicians, and it was true they were liable to make mistakes, but so were other physicians. The doctor who said he would not report a case simply ignored and disobeyed the law. Ignorance of the law was no excuse; he would be held as an accessory if he knew of a crime and failed to report it. The patient whose case Dr. Marx had related was in the house of a midwife who had advertised in the papers for years. The doctors who were called ought to have known this, they ought to have suspected that this woman had committed a crime, and, learning the fact, ought to have reported it to the authorities. If the law requiring us to report such cases was unjust, we should seek to repeal it. Practically, it was only women who died, and who died under suspicious circumstances, whose cases came before the coroner or police authorities, and because of lack of evidence it was of little avail for the physician to report a case until he saw that his patient was likely to die.

The discussion was further participated in by Drs. Tuttle, Vedin, H. S. Stark, Michaelis, and others, and a motion offered by Dr. Stark was adopted, calling for an expression of an opinion from the counsel of the society with regard to the medico-legal position of physicians when called to cases of criminal abortion, this opinion to be printed and distributed among the members.—*Medical Record.*

Clinical Notes.

REPORT OF A CASE OF APPENDICITIS.

By H. Morell, M.D., C.M. (Trin.),
Slayton, Minnesota.

THE object of this history of an attack of appendicitis is merely to give a clinical report of a case which occurred in my practice. My reason for recording it is that I have found very few cases published which were treated medically, and in which the full history of temperature, etc., were recorded. Operation was advised after the first forty-eight hours, but was refused.

B. O., aged 17, female, was taken suddenly ill while walking home from school, a distance of three miles; complained of sudden pain in right side, with vomiting. She thinks she had hurt herself while romping at school. I saw her about 10 p.m. the night after. She has pain in right iliac region, with great tenderness over McBurney's point. The pain comes on at intervals, and extends down the right thigh; no tympanites. Bowels moved this morning. Temperature $101\frac{2}{5}°$. Pulse 100. Tongue slightly coated.

March 10. Temperature $100\frac{3}{5}°$. Pulse 80. No pain. No vomiting. Feels comfortable.

March 11. 11.30 a.m., temperature $102\frac{1}{5}°$. Had a chill the night before. Vomiting. Great pain in right iliac fossæ. 10 p.m., temperature $101\frac{2}{5}°$. No pain. Comfortable, except vomiting. Tongue coated.

March 12. Temperature $101\frac{2}{5}°$. No pain.

March 13. 2.30 p.m., temperature $100\frac{1}{5}°$. Pulse 90. Comfortable. 9.30 p.m., temperature $100\frac{1}{5}°$. Pulse 100. Pain in region of appendix. Movement of bowels with severe pain.

March 14. Temperature $100\frac{1}{5}°$. Pulse 84. Had a good night. Can bear pressure over appendix without pain.

March 15. Temperature $100\frac{4}{5}°$. Pain in appendicular region, with vomiting.

March 16. 11 a.m., temperature 102$\frac{1}{5}$°. Pulse 100. No tenderness. Vomiting. 3 p.m., temperature 103$\frac{1}{5}$°. 8 p.m., temperature 102$\frac{2}{5}$°. The temperature was taken by an assistant. No examination of abdomen made. No pain nor vomiting complained of.

March 17. 12 a.m., temperature 102$\frac{2}{5}$°. Pulse 100. No pain. Vomiting. Slight induration over appendix, with pain on pressure.

March 18. 12.30 a.m., temperature 103°. Vomiting. No pain. Marked fullness in region of appendix. 3 p.m., temperature 103°.

March 19. 10.15 a.m., temperature 102$\frac{2}{5}$°. Comfortable. Bowels moved twice. No pain. Consultation with Dr. Wm. McGillivray, Pipestone, who advised operation. 9 p.m., temperature 102$\frac{3}{5}$°. Vomiting. No pain.

March 20. 11 a.m., temperature 103°. Pulse 100. No pain. The fullness in right iliac fossæ is prominent. Bowels moved easily without injections.

March 22. Temperature 99$\frac{2}{5}$°. No pain. No prominence in right fossæ. No pain on pressure.

March 23. Temperature normal. No pain. Vomiting ceased. Tongue clean. Bowels regular. Feels quite comfortable. Rapid recovery.

The fluctuation in the degree of pain, of course, was due to the influence of morphia.

The treatment which was followed in this case was rest, morphia, and enemata. The inference one would draw from this case would be that the abscess ruptured into the bowel, as a quantity of pus was found in the stools.

Progress of Medicine.

MEDICINE

IN CHARGE OF

J. E. GRAHAM, M.D., M.R.C.P. Lond.,

Professor of Medicine and Clinical Medicine, University of Toronto; Physician to the Toronto General Hospital, and St. Michael's Hospital;

AND

W. P. CAVEN, M.B., Tor.

Lecturer in Clinical Medicine in the University of Toronto; Physician to Home for Incurables.

Physical Signs of Acute Pericarditis.

Josserand, of Lyons (*Sem. Méd.*, November 3rd), remarks that the friction sound in pericarditis is often in arrear of the anatomical evolution of the disease, not being present until a longer or shorter period has elapsed. The following is, in his opinion, an early sign of real value. When, in the course of an acute articular rheumatism, comparative auscultation is made at the cardiac base in the aortic and pulmonary areas, it sometimes happens that the second sound in the pulmonary area is found to be more intense, louder, and more metallic; the opposite is the case in chronic aortitis, in which the sound is more marked on the right side of the sternum than on the left. Sometimes even this difference is appreciable by the hand, which perceives an exaggeration of the diastolic closure shock of the pulmonary sigmoid valves. The existence of this sign should cause one to search carefully for a friction sound, which will then often be discovered when a superficial auscultation would have allowed it to escape notice; if not present, its more or less early appearance may be predicted. This noisiness of the second sound is early, and usually transitory; it precedes the friction sound by from one to three days, and, with few exceptions, is replaced by it. It is a sign proper to the initial congestive period, like the fine crepitation of pneumonia. Its anatomical explanation is, Josserand thinks, that the heart muscle at the base of the pulmonary artery is rendered congested, turgescent, more dense, and, perhaps, covered with fibrinous lymph, and thus amplifies to the ear the neighboring

sigmoid sounds. This sign is important, first in diagnosis, to enable one to decide between a friction sound and an anæmic murmur or extra-cardiac sound, as it permits one to decide in favor of the friction sound; secondly, as a sign that the heart is affected, with localization and intensity difficult to state precisely. It indicates the necessity for early revulsive medication.—*Epitome, British Medical Journal.*

Case of Chlorosis Treated by Red Marrow Tabloids.

The success in a case of progressive pernicious anæmia treated by Dr. Fraser* with red bone barrow (raw) encouraged me to employ the same substance in the shape of tabloids in allied disorders. I quote a case which will illustrate the results I have gained.

B.H., a young lady, æt. 18 years, first came under treatment on July 10th, 1894, complaining of amenorrhœa, dyspnœa, palpitation, constipation, œdema of ankles, and loss of flesh. I ordered her ℞ liq. ferri *m*x, liq. arsenicalis *m*ij, aq. ad. ℥j, t.d.s., and an aloin compound tabloid every other morning.

By August 2nd, 1894, the above treatment had caused but little improvement. She was still suffering from severe cephalalgia, nausea, and faintness on rising in the morning; weakness, anorexia; pallor of face and lips was marked. She was still habitually constipated, highly nervous, and the menses never more than a "show." The pulse was small, quick, and sometimes irregular. There was a venous hum over the great veins, and a systolic *bruit* at base. The red cells numbered 2,800,000 per c.cm. The hæmoglobin was 40 per cent; many of the corpuscles were irregular in shape; not many blood plaques were seen. On August 30th, 1894, after taking four red marrow "tabloids" a day, the subjective symptoms and abnormal cardiac *bruit* had almost disappeared; she looked brighter; appetite was fair; there was no œdema of ankles, the bowels were regular, the menses almost normal. The red corpuscles numbered 3,200,000 per c.cm.; very few irregularly shaped hæmocytes were seen. The hæmoglobin was 70 per cent., and the blood plaques more numerous.

The above case justifies me in recommending these agents (tabloids) in the following conditions: Anæmia; oligæmia from loss of blood (wounds, hæmorrhoids, hæmoptysis, hæmatemesis, etc.); anæmia following acute diseases (typhoid, etc.); tropical anæmia (parasitic or malarial); anæmia of toxic origin; leukæmia or lieno-leukæmia (acute or chronic); and progressive pernicious anæmia.—Forbes, in *British Medical Journal*, December 8th, 1894, p. 1308.

* *British Medical Journal*, June 2nd, 1894, p. 1172.

OBSTETRICS

IN CHARGE OF

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ASSISTED BY

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After the Delivery of the Placenta.

℞ Fl. ext. ergotæ,
Fl. ext. hydrastis canadensis.....aa ℥ iv.
Fl. ext. hamamelis virginicæ....q.s. ad ℥ ii.
M. Sig.: Teaspoonful three times a day.

—Stuver.—*Medical Record.*

Eclampsia of Pregnancy.

Hypodermic of morphia followed with five or ten minims of tincture of veratrum viride by same method.—Page.—*Medical Record.*

Walcher's Position, and its Practical Value in Obstetric Operations.

In the *Archiv für Gynakologie*, 1893, Band 45, Heft 2, Wehle reports the interesting results at the Dresden clinic in employing Walcher's position during delivery in contracted pelves. This procedure consists in placing the patient upon her back at the edge of a bed or table, extending the thighs and allowing them to fall downward as far as possible. Walcher, writing on the subject in 1889 (*Centralblatt fur Gynakologie*, 1889, p. 892), asserted that the conjugata vera of a contracted pelvis varies with the posture of the patient, while Klein (*Zeitschrift fur Geburtschulfe*, Band 21, s. 74) found that the true conjugate and diagonal conjugate undergo a change of five-tenths of a centimetre in various postures of the patient. These observations have been repeated by others, and lately by Wehle, who gives a tabulated list of twenty-five labors in contracted pelves. In these labors the patient was put in this position and delivery was effected by version and extraction. None of the mothers died, but two of them

had fever during the puerperal period. Of the children, 80 per cent. survived. Of these twenty-five cases, seventeen had a conjugata vera of eight centimetres, and in these cases eighty-two and three-tenths per cent. of the children survived. Especial care was to maintain the membranes unbroken, that complete dilatation might be present before the beginning of extraction.

In a recent paper on "Posture in Labor," Jewett (*Brooklyn Medical Journal*, 1894, No. 11) states that he has examined puerperal patients, finding a gain in the antero-posterior diameter of the pelvis, when the patients were in Walcher's position, varying from one-half to three-quarters of a centimetre; in four non-puerperal pelves measured upon the cadaver the gain in this position varied from four to six millimetres.

Fehling (*Munchener med. Woch.*, 1894, No. 44) has recently utilized Walcher's posture in three cases of contracted pelves, in two of which labor was induced; he found that a broad band or girdle passed beneath the axillæ was of comfort to the patients, as the posture tended to cause them to slip down from the bed on which they lay. They could not maintain this position with comfort longer than two or three hours. Fehling makes an estimate of a gain of from six to eight millimetres in the diameters at the brim of the pelvis by this procedure.—*American Journal of the Medical Sciences.*

TREATMENT OF PLACENTA PRÆVIA BY MEANS OF THE INTRA-UTERINE COLPEURYNTER.

Duhrssen (*Deutsche medicinische Wochenschrift*, 1894, No. 19) contributes an article on the above subject. The introduction by Braxton Hicks of the method of treating this condition by means of combined version has given excellent results for the mother, but quite different for the child; the mortality of the latter reaching 60 per cent. The great disadvantages of this method are avoided by the introduction of the uterine colpeurynter, and this can be easily made aseptic. In six cases which the author reports all the mothers did well, and five of the children were born living. Two points are to be carefully observed in this method: (1) To introduce the colpeurynter into the ovisac, the membranes being ruptured. (2) To make steady, regular traction on the distended instrument, so as to compress the detached placental flap against the bleeding uterine vessels. This is best done by making traction through the tube. In 50 per cent. of cases, within three hours the instrument is expelled by uterine contraction, and birth ensues.

Not over half a litre of water should be put in the bulb. Cremaillier's long ball forceps are the best for introducing the folded colpeurynter into the uterus, and the introduction is practicable whenever the fingers can be

introduced into the cervical canal. The finger should remain in after the bag is introduced until it is filled properly. If it be necessary to remove it, the fingers must be disinfected and carried up to the bulb, but no effort should be made to withdraw it by dragging on the tube.—*American Journal of the Medical Sciences*

POTASSIUM NITRATE IN THE TREATMENT OF PHLEGMASIA ALBA DOLENS.

Hovnanian describes his use of nitrate of potassium in this affection in the *Medical News* of July 28, 1894.

It has fallen to his lot to treat three well-marked cases of phlegmasia alba dolens with potassium nitrate with such gratifying results as to seem to justify publication.

Mrs. H., twenty-three years old, was delivered of her first child by her family physician with instruments, and sustained extensive lacerations of the cervix uteri and perinæum, which at the time were not repaired, but were left for a secondary operation. Twelve days after delivery she complained of pain and heaviness in the left leg, and within three days there developed well-marked phlegmasia. On the fourth day of this complication the writer saw the patient in great agony, with a temperature of 105.2° F., a pulse of 130, and respirations 25. The limb was so turgid and swollen that there seemed to be great danger of gangrene or rupture. The woman was at once given morphine sulphate (⅓ grain) hypodermically, and her limb was wrapped with cotton and placed on a feather pillow at a very obtuse angle. Hovnanian then prescribed a solution of potassium nitrate in water, representing 5-grain doses, to be given every hour until his return. Seven hours later he found his patient in better condition, with a temperature of 103° F., a pulse of 112, and respirations 22, and with less pain and discomfort. The swelling seemed to be less tense and the veins less engorged. The nitrate was continued as before until morning, when he found her in yet better condition. She had slept well during the night, although she had been wakened regularly for her medicine. Her temperature was 100° F., her pulse 95, her respirations 20. The swelling was reduced to less than half, and the returning circulation was fairly well established. There was no pain whatever, and but slight tenderness on pressure. The medicine was continued every two hours during the day, until the author saw her late in the evening, with a temperature of 99° F., a pulse of 90, and respirations 18. The swelling had almost entirely gone, and everything was in good condition. The nitrate was continued for two days in smaller doses, and at longer intervals, and then discontinued.

Two other equally typical cases are also recorded in this paper.—*Therapeutic Gazette.*

SURGERY

IN CHARGE OF

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AND

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Obliterative Arteritis in a Boy Fourteen Years of Age.

An unusual case of this interesting condition, occurring in a young boy, is reported in *The Lancet* by Mr. B. W. Bond, M.B. The case is thus reported by Mr. Bond:

"A boy fourteen years of age came to me suffering from a sharp attack of 'shingles,' extending round the left side of the chest and back. He was evidently in bad health, and on taking his left wrist to feel his pulse I discovered that none could be felt. No pulse could be felt anywhere in the left upper extremity until the subclavian was reached. Here the beat was synchronous with that of the right subclavian, but much feebler. The radial and brachial arteries could be felt as cord-like bodies. On questioning the boy, he said that beyond occasionally having 'pins and needles' in the left arm and fingers he had felt no inconvenience whatever, and, in fact, he was unaware of the condition. He usually suffered from chilblains during the winter months, especially on the feet. The collateral circulation was evidently good, for beyond a slight blueness of the fingers there was no other visible sign of deficient nutrition. The temperature of the fingers was practically the same on both sides, and there was no anæsthesia. As regards cause, there was no sign of cervical rib or other pressure on vessels, the heart sounds were normal, and no specific or rheumatic history could be obtained. There were no signs of congenital syphilis elsewhere. The pulse in the right radial was normal, and no undue thickening of arterial walls could be felt. The interest of the case lies in the early age of the patient. I have seen a similar condition at the age of twenty-three and twenty-four years, but believe it to be rarely seen in a patient as young as fourteen years."

Death under Nitrous Oxide Gas due to Tight-Lacing.

More than one fatality from tight-lacing has recently been noticed in our columns. In all conditions in which free respiration becomes a necessity, if the vital processes are to be carried on, tight-lacing means death. Of all states, that in which a patient takes an anæsthetic is the one when absolute freedom of breathing is a necessity. Unhappily, but few know this elementary fact in physiology, and hence the sad death of a girl who had taken nitrous oxide gas at a dentist's rooms, and while recovering from its influence had a fatal attack of syncope. The statement is made that her stays were five inches too small for her natural body, a disparity of shape which, we imagine, the dentist might have seen and acted upon before he ventured to give the unfortunate girl nitrous oxide gas.—*Lancet.*

Ligature of the Carotid Artery for Cerebral Hæmorrhage.

It will be remembered that some time ago, in a series of experiments on monkeys, Mr. Horsley and Mr. Spencer found that hæmorrhage in the basal ganglia could be controlled by ligature of the common carotid artery, and they suggested that ligature of the artery was a procedure which might be adopted in cases of ingravescent apoplexy. In a recent number of the American *Journal of Nervous and Mental Diseases* Dr. Dercum and Dr. Keen, of Philadelphia, relate two cases which have a considerable amount of interest with reference to this point. The first was that of a man aged fifty, who on the morning of February 11th had experienced a slight weakness of the left arm. In the evening of the same day there was also noticed some weakness of the left leg. Medical advice was now sought, and wet cups were applied to the back of the neck, a purgative was administered, and ergot and bromides were given. On the following day the one-sided weakness was slightly greater, on the day after it increased, and was apparently becoming steadily worse at the close of the fourth day from the onset, when there was complete motor palsy of the left arm, decided weakness of the corresponding leg, and paralysis of the lower half of the left side of the face. There was no affection of sensation, and no headache, only a dull feeling in the head, and slight giddiness, without any obscuration of intelligence. The urine contained a small quantity of albumin. It was thought that the condition was most likely one of ingravescent apoplexy, and Dr. Keen was asked to ligature the common carotid artery on the right side. This was done, cocaine only being used locally. No increase of the paralysis was observed after this, and two days later an appreciable improvement had taken place, the patient being now able to move his left hand and fingers. Improvement continued, and the condition at the end of two months showed a slight spastic condition of the left leg, with drooping of the left side of the face, and weakness of the left hand

and arm. There was no anæsthesia, and the mental condition was in no way impaired. The second case was that of a man attacked at two o'clock one afternoon with weakness of the left arm. The same evening the weakness was greater, and had involved the leg and face on the same side. Ingravescent apoplexy was diagnosed, and ligature of the common carotid artery decided upon, but before it could be carried out it was late at night, and the paralysis had deepened and unconsciousness had supervened. The operation failed to relieve the patient, however, and he died a few hours later. The publication of these cases will direct attention anew to a subject of much practical interest and importance. It is obvious that, in reference to any operative procedure in such cases as those here related, the great question is one of diagnosis. However likely the diagnosis of increasing hæmorrhage was in the first case, even the success which followed the operation does not absolutely settle the question; and it cannot be asserted that the success was more than a subsequent fact. It is unfortunate that no necropsy was obtained in the second case.—*Lancet.*

The Calibre of the Human Intestine.

In communicating to the Société de Chirurgie the results of some experiments he had carried out on dogs with Murphy's anastomosis button, M. Chaput made a statement* which seems to us to open up a field for speculation, if not for enquiry. Basing his opinion on numerous measurements of the human intestines, the distinguished French surgeon informed his audience that the twenty-seven millimetre button is far too bulky for the small gut in general, and especially for the lower end of the ileum. Of the three sizes, he prefers that which is about equal to twenty-one millimetres in diameter; it is the smallest, and adapts itself to the situation more readily than the others. Now, the questions suggested by M. Chaput's remarks are these: Do American citizens, as a rule, possess more voluminous intestinal tracts than their French congeners, and, if so, how far is cookery responsible for the difference? It is, of course, notorious that French cooking is the best in the world: has this fact any bearing upon the presumably small calibre of the French bowel? Digestion being made easy, so to speak, is it the case that a partial arrest of development has been the consequence? Is there also discrepancy as regards the length between the *primæ viæ* of the two nationalities? Savages are endowed with magnificient mouth furniture, and dental decay is sometimes said to be a product of civilization, dependent to a great extent upon knives and forks! Has the human race any reason to dread analogous deterioration as a corollary to elaborate cookery? Finally, and by way of closure to these *obiter dicta*, are dainty dishes a physiological mistake?—*Lancet.*

* "Gazette Hebdomadaire des Sciences Medicales de Bordeaux," No. 47, November 25th, 1894.

GENITO-URINARY AND RECTAL SURGERY

IN CHARGE F

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FURTHER EXPERIENCE IN THE EFFECT OF SIMULTANEOUS LIGATION OF BOTH INTERNAL ILIAC ARTERIES FOR HYPERTROPHY OF THE PROSTATE GLAND.

Dr. Willy Meyer read a paper with the above title before the section on Genito-Urinary Surgery, New York Academy of Medicine, December 11, 1894. He stated that this method of reducing the size of the enlarged prostate was first introduced by Dr. Bier, of Kiel, whose experience with the operation was published in the *Wiener klinische Wochenschrift*, August 10, 1893.

Up to the present time, Dr. Meyer has performed the operation three times. The first one, which was performed on October 5, 1893, was reported in the July (1894) number of the *Annals of Surgery*. In that case, several days after the operation there was secondary hæmorrhage, due to pressure necrosis of the external iliac artery, which necessitated tying off the common iliac. Soon after this, gangrene of the toes and part of the metatarsus developed on one side, which later on required amputation of the anterior portion of the foot. So far as the effect of the operation on the prostate was concerned, the result was very satisfactory. Twelve hours after the operation the patient began to pass his urine voluntarily in a very thin stream, and during the following two weeks he frequently voided small quantities through the urethra, but he also had to be catheterized. The improvement gradually continued, and he is at present able to hold his urine for two hours and then pass ten or twelve ounces in a forcible stream.

The second case was operated on May 21, 1894. The patient was a man aged sixty-three years, who suffered from retention of urine due to hypertrophy of the prostate. A single silk ligature was placed around each internal iliac artery within its sheath and The two wounds

were then sutured with catgut, layer by layer. There was no reaction after the operation, and the wounds healed by primary union. During the night following the operation the patient voided his urine a number of times in a fine stream. Retention did not again set in. On the fifth day he suddenly developed subnormal temperature without any apparent cause, and died in a comatose condition on the eighth day.

In the third case reported only the left internal iliac was successfully tied, and this was followed by decided atrophy of the corresponding side of the prostate gland.

Dr. Meyer said he will continue doing this operation in suitable cases, namely, patients with "recent" retention, where marked dilatation with atony of the bladder has not yet set in. The operation is not at all difficult if the patient is placed in the Trendelenburg posture, and the artery can be tied on both sides within one hour. In tying it he employs silk, one ligature being sufficient, after having opened the sheath of the artery. The wound should be closed entirely by means of buried sutures. The operation should be an extraperitoneal one.

In conclusion, Dr. Meyer said that if further observations prove equally satisfactory in regard to the final result of simultaneous ligation of the internal iliacs, this must necessarily become the standard radical operation for hypertrophy of the prostate. It leaves the parts in their normal anatomical relation, and removes the obstruction in the simplest way—*i.e.*, by producing progressive atrophy of the organ which causes the obstruction. It also keeps the patient in bed for only ten to fourteen days, the wounds healing by primary union under the first dressing.

Dr. Samuel Alexander expressed the opinion that in patients with atheromatous arteries, tying off the internal iliacs might cause dangerous secondary hæmorrhage. While cutting off the blood supply in this way tends to produce atrophy of the prostate, still he thought the operation, for the present, at least, should be presented to the patient, not as a recognized surgical procedure, but as a physiological and surgical experiment.

Dr. Fuller said he agreed with the views expressed by Dr. Alexander. In most of these old patients with enlarged prostate there is a condition of general arterial sclerosis, and by cutting off so large a portion of the blood supply of the lower extremities gangrene might be produced.

Dr. C. W. Allen said that the operation of simultaneous ligation of both internal iliacs for the relief of a hypertrophied prostate is certainly a fascinating one, both for the surgeon and the patient. If further experiments show that its performance is not followed by gangrene or other untoward results, he saw no reason why the operation should not take its place among other well-recognized surgical procedures.

Dr. Meyer, in closing the discussion, said that the recent investigations of Bier have shown that arterial sclerosis is not of very frequent occurrence. The danger of secondary hæmorrhage is slight. While the operation must still be regarded as an experiment, still, all operations when first undertaken were experiments. The gangrene of the foot which occurred in one of the cases reported in the paper was not due to tying off the internal iliacs; in that case the common iliac was tied. In the future he would not perform the operation on patients over the age of sixty. It is, of course, not applicable to all cases; some patients with hypertrophy of the prostate must be relieved in one way, others in another.

Dr. R. Guiteras exhibited a small plug which, he stated, he has found very serviceable in cases where the catheter is left *in situ* for longer or shorter periods. It is inserted into the outer end of the catheter, and prevents the dribbling of urine. The plug, which is made by Tiemann, is graduated so as to fit almost any sized catheter.—*Journal of Cutaneous and Genito-Urinary Diseases.*

[NOTE.—The surgery of the prostate is occupying a considerable amount of attention at the present time. Any rational procedure that will give permanent relief in the exceedingly troublesome disease is worthy of the fullest investigation. In the light of recent investigations by White, of Philadelphia, Belfield, of Chicago, and others whose procedure is far less severe than the above, I am of the opinion that the sentiment expressed in the discussion will prevail. The record of the three cases quoted is not inviting.—E.E.K.]

SUDDEN DEATH IN CONSEQUENCE OF A URETHRAL INJECTION OF COCAINE.

In the *Centralblatt fur Chirurgie* for March 10, we find an abstract of an account published in *La France medicale* by M. Reclus, of a case in which sudden death followed an injection of about six drachms of a five per cent. solution of cocaine into the urethra. The urethral mucous membrane appeared to be quite intact, and the death was attributed to pronounced arterio-sclerosis and to the undue quantity of the drug employed.

[In the above case, 15 grains of this drug are used—a dose so large that no excuse can be offered. I have seen syncope follow 2 grains injected in the urethra, and unpleasant symptoms follow 1½ grains; while no systemic symptoms have shown in 3-grain injections.—E.E.K.]

PÆDIATRICS AND ORTHOPÆDICS

IN CHARGE OF

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AND

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Gastro-Enteritis in Infants.

From examinations of the blood of infants suffering from gastro-enteritis, conducted in Professor Epstein's clinic at Prague, and recorded in the *Lancet*, A. Czerny and P. Moser think that this affection is to be regarded as a general infection of intestinal origin. It is, therefore, different from dyspepsia, in which the disease remains limited to the gastro-intestinal tract. Thus, out of fifteen cases of gastro-enteritis in which the blood was examined during life, in twelve the presence of micro-organisms was ascertained. On the other hand, in only two out of thirty healthy children were cultures obtained from the blood, and of eleven infants suffering from dyspepsia only one yielded that result. The microbes found circulating in the blood in subjects of gastro-enteritis comprised staphylococci, bacterium coli commune, bacillus pyocyaneus, and bacterium lactis aerogenes, all of which are known to occur in the intestinal contents. It is pointed out that this variety in organisms concords with the multifariousness of the symptoms of gastro-enteritis, whilst it shows that prophylactic measures are more hopeful than therapeutical, the value of which latter must depend on the kind and intensity of the general infection.—*Maryland Medical Journal*, 1895, xxxii., 363.

Antipyrin in Large Doses in Epilepsy and Chorea.

McCall Anderson, in the *British Medical Journal* of Dec. 1st, 1894 advocates strongly the use of antipyrin in large doses in the treatment of epilepsy and chorea. He is opposed to the idea that antipyrin is a dangerous drug; and claims that very large doses can be given without the slightest difficulty, if only the initial dose be not too large and the large

dose gradually reached, commencing, say, at ten grains three times, and raising one grain in the dose daily.

As examples of results obtained from the use of antipyrin in large doses, the following cases are given :

CASE 1. Boy, æt. 9 years, suffering from fits of two and a half years' dura tion. At the beginning of the illness he had fits very frequently, and after some months they gradually lessened until completely gone. He remained well for fifteen months, but seven months before admission they returned, commencing with one fit in twenty-four hours, and increasing until they amounted to forty and fifty in the day. The seizures were of the ordinary epileptic type, some followed by clonic spasm. Treatment began on December 20th, and consisted of rest in bed, regulation of bowels, and the exhibition of antipyrin, beginning at five grains three times a day, and increasing the dose by one grain every day. On January 9th twenty-five grains thrice daily were reached, and this dose was continued until January 16th, when the dose was reduced to twenty grains three times a day. From date of admission, December 12th, until December 20th, the daily average of fits was 16.5 ; from that till December 30th, 13.2. On December 31st and January 1st there were eleven fits ; on January 2nd and 3rd there were ten fits, and on January 4th three. They ceased until January 28th, when there was one slight fit. For twelve days before the 28th the dose of antipyrin had been lowered. The antipyrin was gradually increased again to twenty-five grains thrice daily. No further fits. Patient discharged quite well on March 1st. He continued taking antipyrin at home, and a letter from the father, dated March 12th, stated that up to then he had had no recurrence.

CASE 2. Boy, æt. 12, admitted October 10th, 1892. Suffering from second and severe attack of chorea. Has not improved as before, and has been under treatment at a dispensary since June. The movements are quite marked and incessant. He spills at least part of the water he attempts to swallow. There is slight difficulty in speech and a faint systolic murmur. The case was treated by antipyrin. On October 11th he received fifteen grains in three doses, and as the drug agreed well it was rapidly pushed. On the 13th he had thirty grains ; on the 15th forty-five grains ; on the 17th sixty grains, and so on, until on November 14th he was taking fifty grains three times a day. He was about a fortnight under treatment before the symptoms began to abate, when he was getting thirty grains thrice daily. He left the infirmary perfectly well on November 25th, the dose having been maintained at fifty grains three times a day until his dismissal. He was instructed to gradually diminish the dose and has since remained well.

CASE 3. Female, æt 12. Admitted December 17th, 1892, with a violent attack of chorea of a month's duration. This was the third attack.

She has extremely violent movements. Cannot walk or sit on a chair. It was necessary to lie her down in bed. On December 17th she took in all twelve grains of antipyrin; on the 18th she took ten grains thrice daily; on the 19th, fifteen grains; on the 21st, twenty grains; on the 25th, twenty-five grains; January 6th, thirty grains; January 12th, thirty-five grains; January 16th, forty-five grains three times a day. Drug not increased any further, as there was slight headache and sickness. Improvement was very rapid. She was able to sit by the fire on January 7th. Movements still persisted, but they became very slight, and were confined now to the left leg and hand. After January 16th the drug was twice stopped for a day owing to sickness. On January 23rd the dose was reduced to forty grains thrice daily, and Easton's syrup was given. The dose was then gradually reduced. Slight movement of the right hand persisted for a time, but this also finally disappeared. She was dismissed quite well on March 7th, 1893. Mr. Anderson sums up his experience in the following aphorisms:

(1) Antipyrin is not the dangerous drug some observers have led us to suppose.

(2) It may be given with safety in large doses, even in case of children, in most cases, although the initial dose must be small, and it must be slowly and cautiously increased.

Ice Creams and Bacteria.

In the *Medical Record*, 1895, xlvii., 168, Her Klein gives results of examination for bacteria of ice cream sold in the streets, and also of the water in which the glasses were washed. In all, six samples were examined, and in each immense numbers of pathogenic and other germs were found. So abundant were these organisms that the author asserts that in this respect the ice cream was not inferior to ordinary sewage. Many of the forms identified bore striking resemblance to those diagnostics of typhoid fever. In view of these facts the importance of supervision of food materials of this kind cannot be overestimated.

PATHOLOGY

IN CHARGE OF

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The Micro-Organism of Chronic Rheumatism.

Schüller (*Medical Record*, September 23, 1893) has found a specific bacillus for chronic rheumatism. The organisms are described as measuring 2.6 x 0.85μ, and are constricted at the middle. They stain well with carbol-fuchsin, but are easily decolorized by acids. They are said to grow fast at 25°C. in the dark. All the ordinary culture media are fitted for their development. Schüller inoculated the joints of rabbits with cultivations obtained from human joints, and succeeded in producing a non-suppurative arthritis analogous to the rheumatoid arthritis affecting man. The chronic rheumatism seems to be an entirely different disease from the acute, from which Schuller has only succeeded in cultivating staphylococci and streptococci, never the specific bacillus described above.—*University Magazine.*

On Transmissibility of Cancer from Man to Animals.

M. Boinet, after a long series of experiments on the transmissibility of carcinoma from man to animals, states that after having made repeated inoculations on the rat, the rabbit, and the guinea-pig, he concludes that histologic examination of the lesions which resulted does not authorize him to pronounce in favor of such transmission.—*Semaine Medicale*, November 3.—(*Journal of American Medical Association.*)

The Eclampsia Bacillus and its Relation to Puerperal Eclampsia.

Gerdes (*Deutsche med. Wochenschrift*, xviii., p. 603) succeeded in cultivating, from the serous contents of the abdomen, pleuræ and subdural spaces, as well as from the liver, kidneys, spleen, lung and aorta blood, of

a patient dead of puerperal eclampsia, a peculiar and characteristic bacillus. The colonies appeared as little points in twenty-four hours. Microscopic examination of the organs mentioned showed immense numbers of the bacilli. Experiment proved the bacilli infectious.

The author is of the opinion that the decidua is the primary seat of infection. The conclusions reached by him are as follows :

(1) The eclampsia bacillus is the only cause of eclampsia, and is not found in any other disease. There is no eclampsia without bacilli. The infection takes place from the uterus, probably from an endometritis which existed before the time of conception.

(2) The convulsions which take place from other causes at the time of birth must be most carefully separated from eclampsia, and are shown by post-mortem examination to be entirely different.

(3) Eclampsia is a very distinct and characteristic disease.

(4) The severe changes which the organs of eclampsia patients suffer cannot be explained on the ground of the demonstration of the specific micro-organisms. Probably they are the direct or indirect result of the toxines of the eclampsia bacillus.

THE EXAMINATION OF STREET DUST FOR TUBERCLE BACILLI.

Marpmann (*Centralbl. f. Bakt. u. Parasitenk.*, August 25th, 1893, Vol. xiv., No. 8, p. 229) observed that in old sputum the tubercle bacilli no longer presented their characteristic shape and appearance, but presented the appearance described as an "involution form." Further than this, the bacillary form sometimes entirely disappeared, the bacilli appearing only as granules, which stained by the characteristic methods. Marpmann conceived that tubercle bacilli might be present in the atmosphere in this granular form, and by carefully investigating the dust of various streets discovered that these granules were present sometimes in considerable numbers.

The method employed was as follows : The dust was collected in the morning, and allowed to digest in water at 40° C. for about an hour, filtered through a woollen cloth, and the filtrate, of which there should be fifty cubic centimetres, mixed with about ten drops of ammonia carbonate solution. After some time a precipitate of ferrous oxide and earthy carbonates is found. The precipitate is allowed to collect in a pointed glass, or is separated by a centrifugal machine, and stained with carbol-fuchsin in the ordinary way. When old sputum is examined by this method, the number of granules is large. In dust each cover-glass contains a very few, say five to ten.

Satisfied that these bodies represented the tubercle bacilli, Marpmann determined to test their vitality, and making use of the discovery made

by Vissmann, that the tubercle bacilli could resist prolonged exposure to steam, succeeded in obtaining from street dust pure cultures of the tubercle bacillus.

The dust was first subjected to a careful investigation for the presence of the granules mentioned above. If they were found, the following method of cultivation was attempted. The dust was digested in water, filtered, precipitated, etc., as above, and then inoculated into a culture medium, after which it was boiled for an hour. From this boiled mixture tubes of bouillon and agar were inoculated, and, after being filled with an atmosphere of pure oxygen, were hermetically sealed, and stood in the incubator for four weeks. At the end of this time examination showed the bouillon sterile and a growth of tubercle bacilli on the agar.

These discoveries are of great importance to students of hygiene, and show what disastrous consequences the expectoration of tubercular sputum upon sidewalks may cause by dissemination of its contained micro-organisms.

Tuberculosis of the Stomach.

Edward Przewoski has observed five cases of this affection, finding the tuberculous ulcers to be usually located in the pyloric region, though sometimes met with in other parts of the mucous membrane. Generally there was but one ulcer; rarely, several ulcers were united into one large ulcerating surface. In all five cases there was at the same time a tubercular affection of the lungs, of slow progress; and the author believed the gastric affection to be due to tubercle bacilli from swallowed sputum, the predisposing causes in the stomach being (1) chronic catarrh, with diminished acidity of the gastric juice; (2) the abundance of lymphatic nodules in the mucous membrane, especially in the cardiac and pyloric regions; (3) the length of time which the gastric contents containing the tubercle bacilli remain in the stomach; (4) accidental injury or rupture of the mucous membrane. Gastric ulcers differ from intestinal ulcers in that the submucous tissue plays the principal rôle, the muscular and serous tissues rarely being involved, while there are comparatively few bacilli. Tubercular ulcers of the stomach have little clinical significance unless followed by hæmorrhage or perforation, which is rare.—*Brodowski's Festschrift*, Warsaw, 1893.—(*Universal Medical Journal.*)

HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

WILLIAM OLDRIGHT, M.A., M.D. Tor.,

Professor of Hygiene in the University of Toronto; Surgeon to St. Michael's Hospital;

AND

E. HERBERT ADAMS, M.D., D.D.S.

Assistant Demonstrator of Anatomy, University of Toronto; Physician to Victoria Hospital for Sick Children; Clinical Lecturer on Diseases of Children in the Woman's Medical College.

To Save the Babies.

The French Government, despairing of any hope to increase the birth rate of that country, is now devoting its energies to saving those already born. The new law forbids, under a severe penalty, any one to give infants under one year any form of solid food unless such be ordered by a written prescription, signed by a legally qualified physician.—*Medical Herald.*

Training Asylum Attendants.

The authorities of the Ohio State Asylum for the Insane are adopting the method of giving a course of lectures bearing on insanity to the attendants of the asylum. The purpose of the course is to more thoroughly acquaint the attendants with the duties they have to perform, with the responsibilities incident to their positions, and to give them a more adequate knowledge of insanity as a disease and its treatment from a scientific standpoint. Some such plan should be adopted with the attendants in the asylums of Ontario.

A Laboratory Necessary.

Diphtheria, for instance, which of late years has become one of the most destructive diseases of urban life, is not readily distinguished in some of its forms from milder and non-contagious affections of the throat and air passages. This difficulty of detection sometimes leads to the infection of others not warned of the unrecognized danger; and then, too, in the treatment of diphtheria the life of a patient may hang on the few hours spent in developing the true character of the disease.

Fortunately, modern science enables us by the culture tube and microscope to discover the specific cause of certain diseases long before

their nature is manifested by the symptoms. In the nature of things this important work cannot be done by each practitioner for himself, and it is conceived that no more valuable service can be offered the community than that afforded in this direction by a properly equipped laboratory under the charge of experts in this branch of modern preventive medicine. By this means it is intended to put at the disposal of every physician the the necessary agencies through which he can secure in a few hours the positive determination of any case of suspected diphtheria, and other diseases of a similar character, which may occur in his practice.—A. R. Reynolds, M.D., Commissioner of Health, Chicago, Annual Report, 1893.

Tuberculosis.

Tuberculosis is at present receiving a great deal of attention, particularly in Massachusetts. The effect of the Cattle Commission's inspections in that state for the detection and destruction of infected cows is seen at the Boston yards in the improved quality of the animals received there from drovers. The inspections at the two yards revealed for the first two weeks a tuberculous proportion of about twelve per cent. Recently, however, the drovers have exercised more care in the selection of cattle designed for these markets, and the result is that late inspections show a much smaller per cent. of infected animals.

Bovine Tuberculosis.

Considerable activity is being manifested by the public health authorities in some of the Eastern States in renewed attempts to exterminate tuberculosis in cattle. In New York, recently, thirty tuberculous cows belonging to a choice herd were killed at Elmira, but criticism is made that the commissioners take such action only upon the request of owners—usually of costly cattle for the protection of the remainder—and that no systematic inspection is made of the common dairy herds, which furnish the milk supply, and which are generally kept under conditions that favor the development of the disease. In Massachusetts such a systematic inspection has been begun, with the avowed purpose of examining every cow, bull, and calf, beginning at Cape Cod and extending westward until the whole state has been covered; the tuberculin test is employed, and every animal that shows the characteristic reaction is to be slaughtered forthwith. On the recommendation of its Sanitary Committee the Philadelphia City Board of Health has also adopted the tuberculin test, and, after sixty days' notice, any milk producer supplying the city who fails to furnish a clean bill of health for his dairy—based upon the results of this test—will be liable to have his milk supply rejected as suspicious and its sale prohibited.—*Journal of the American Medical Association.*

Editorials.

THE PATRONS' MEDICAL BILL.

THE Patrons of Industry decided that it was one of their most solemn duties to reorganize the medical profession of Ontario. Their leader introduced the now notorious bill to amend the Medical Act. We understand that a great deal of work was expended in its preparation, and that much assistance was derived from certain doctors. Who were the doctors consulted? Was there one respectable or reputable physician? No; it was deemed expedient to consult only men who had disgraced a profession which, in the interests of the Patrons and the public generally, should be kept as nearly respectable as human law can make it. The result in the Patrons' eye, we are told, was truly magnificent. No such bill had ever before been brought before the Legislature. Well—in a sense, they were right; and so thought an overwhelming majority of the members, who showed their thorough appreciation of its extraordinary qualities by suddenly killing it in a very inglorious manner (from a Patron's point of view).

Mr. Patron Haycock's marvellous production was printed and sent to the members of the profession throughout Ontario, who had thus ample opportunities for studying carefully the results of the combination of the inborn genius of the broad-minded Patron with the cunning and greed of he contemptible charlatan in what may have been considered by both parties to the contract a lofty labor of love. Our physicians have honored Mr. Patron Haycock by giving his bill some consideration, and have failed to recognize those beauties so eloquently depicted by that greatest of modern statesmen—Haycock. It is only fair to state, however, no matter what thoughtful and well-meaning doctors may think or say, that this same Patron Haycock has become celebrated, and that his mighty brain has evolved the sort of a bill that has never before entered into the comprehension of any Canadian statesman. Who but Mr. Patron Haycock could have done it? We know not. Will Mr. Patron Haycock be unknown to posterity? We think not. Will expecting mothers feel dis-

appointed because they cannot be delivered by cheap and ignorant midwives? Possibly they may. Will unborn babes turn in their mothers' wombs because they cannot hope to fall into the hands of cheap grannies? We are not certain. Will fond and loving husbands be sorry that their wives cannot be placed in the hands of ignorant old women during the pangs of labor? Perhaps—if they are very fond, and very loving, they may. Some will not. Will numerous classes of patients bitterly regret that they cannot be fleeced by the army of dishonest quacks that Mr. Patron Haycock's bill would have called into existence? Many will; and to such the illustrious Haycock will, probably, long appear to be the greatest would-be patriot and benefactor of modern times.

THE DISCUSSION IN THE LEGISLATURE.

THE discussion of the proposed Act in the Legislature was, though brief, very satisfactory. We have extracted, partly from *The Globe*, and partly from *The Mail and Empire*, a fairly good report, which we publish in this issue. The recently-developed statesman, Mr. Patron Haycock, the meteor from proud Frontenac, spoke, we are told, in his happiest strain. The majority of the Patrons listened to him with joy. The common members felt the solemnity of the occasion, and trembled. The reporters were visibly affected. The orator spared neither the Medical Council nor those Toronto doctors who were earning a livelihood by selling blank death certificates to undertakers at twelve dollars a dozen. One Patron, we are told, actually, for the moment, almost felt sorry that he had returned his railway pass; because he thought that he would like to travel round the country and tell the people what his great leader thought of a profession which the new party of patriots were going to reorganize.

It was quite a matter of surprise to the earnest but modest patriots to discover that the Premier was really not captured, either by their chieftain's eloquence, or the beauties of their reorganizing bill. He actually had the audacity to oppose it, to criticize it. He went so far as to say that the bill was not in the public interest. He expressed some extraordinary (as the patriots thought) opinions about the medical profession, to the effect that it was important, respectable, and honorable, and should not be revolutionized. He went further, and expressed the opinion that it should be kept respectable and honorable; he even objected to a lowering of its standards in any way. A tear rolled down the cheek of the Patron chieftain when he went so far as to intimate that he had no sympathy with Mr. Patron Haycock's beloved friends—the impudent and dishonest quacks and scoundrels who desired mediæval free trade in medicine. Strange as

it may seem to the patriots, it happens that the respectable members of the profession, Grit and Tory alike, throughout the Province of Ontario, are ready to assert, without any hesitation, that Sir Oliver Mowat's speech on this Patron bill was able, manly, and statesmanlike in character—one of his best efforts in the House for many years. Strange—how people do differ about statesmanship! Well, Sir Oliver was bad enough, but Mr. Whitney, for the Opposition, "was something awful." We may as well tell Mr. Whitney frankly that we have our own opinion about any member who will use such terms as a "squad of adventurers" in connection with such a Body of Men as the Patron Patriots.

THE COUNCIL DISCIPLINE COMMITTEE.

THE Toronto *World* has expressed the opinion that Mr. Patron Haycock's highest aim in life is to obtain cheap sugar and cheap obstetrics. We must all admit that there is something to admire in an aim so lofty. We are also informed that, in accordance with the customs of Mr. Haycock's cheap grannies in the outlying districts of Frontenac, the chief articles of diet for young infants are brown sugar and butter; and that, while it was the statesman's chief desire to make the sugar and the midwives as cheap as possible, he also had in contemplation an offer to furnish certain grades of butter at the lowest possible rates.

Whatever the truth may be as to these important items of detail, we cannot help thinking there was something in the patriot's bill that was even nearer and dearer to him than cheap obstetrics, viz., the clause which relieved his beloved friends from their greatest terror in life, the Discipline Committee of the Medical Council. Mr. Haycock's distinguishing characteristic, which even towers above his wondrous qualities of statesmanship, is his loyalty to his select coterie of medical friends, who desire free license to engage in conduct that is "infamous and disgraceful." Mr. Haycock, who knows all things, of course knows that the licensed quacks and charlatans have a tremendous pull over the other fellows of the same kidney; hence his mighty and prodigious efforts to destroy that abnoxious abomination, the "Discipline Committee."

There is, of course, something touching about that sort of loyal devotion to one's friends; but there happens to be, in this cold world, a number of people who fail to appreciate all the beauties of such nobility of character. There are several inhabitants of the province who actually think it undesirable, at the present, to remove any machinery which assists in any degree in preventing practitioners from doing that which is infamous and disgraceful.

MR. PATRON HAYCOCK'S SUPPORTERS.

WE feel that it is our solemn duty to place before the profession a list of those who stood by the patriot Patron Haycock in his efforts to secure cheap sugar, cheap obstetrics, and broad, free trade in medicine. As we understand the matter, fourteen out of fifteen who voted with the patriot were regular Haycockers, while one—Mr. Murdo Y. McLean—is not strictly speaking a Haycocker, but simply a high-minded, a broad-minded, and a deep-minded Grit, who occasionally leans towards Haycockism. Mr. Murdo Y. McLean lives in the town of Seaforth, in the south riding of the county of Huron. How would it do for the Huron and Bruce Medical Association to make Mr. Murdo Y. McLean one of its honorary members? Mr. Murdo Y. McLean possesses good parts, and lots of them, and might be able to give this active association some good pointers.

The following is a complete list of the Haycockers, together with Mr. Murdo Y. McLean, who is sometimes a Grit, sometimes a Haycocker, and sometimes both :

NAME.	POST OFFICE.	COUNTY.
John Bennett,	Tayside,	Stormont.
John Caven,	Picton,	Prince Edward.
Archibald Curry,	Creemore,	West Simcoe.
William Dynes,	Grange,	Dufferin.
Thomas Gamey,	Maxwell,	Centre Grey.
Joseph Longford Haycock,	Cataraqui,	Frontenac.
George N. Kidd,	Carp,	Carleton.
John S. McDonald,	Ripley,	Centre Bruce,
Alexander McLaren,	Melrose,	East Hastings.
Murdo Y. McLean,	Seaforth,	South Huron.
Daniel McNaughton,	Underwood,	North Bruce.
John McNeil,	Fullarton,	South Perth.
David McNichol,	Lamlash,	South Grey,
David McPherson,	Lancaster,	Glengarry.
William Shore,	White Oak,	East Middlesex.

TRINITY MEDICAL ALUMNI ASSOCIATION.

THE third annual meeting of the Trinity Medical Alumni Association, which was held in the Convocation Hall of Trinity University, Thursday, April 4th, was a very pleasant and successful affair. We publish elsewhere in this number a report of the proceedings. The programme

was an excellent one, and the various gentlemen whose names appeared responded promptly to the calls of the president, Dr. Geo. A. Bingham, at the hour named.

On the same evening, the annual banquet was held in the Rossin House, and was fairly well attended by members of the association and their guests. Among the latter were the visitors from the United States, and a few local physicians. A very enjoyable evening was spent, the speeches, *moral tales*, and songs being above the average. The association is evidently in good shape—well officered and well managed; and its friends think that its prospects of future success are of the brightest sort.

THE BUFFALO MEDICAL JOURNAL.

THE Buffalo *Medical Journal* was first published in 1845, and will be fifty years old in a few weeks. The worthy editor, Dr. William Warren Potter, who is so well and favorably known both in the United States and Canada, announces that he proposes to signalize its semi-centennial anniversary by increasing its reading pages from sixty-four to eighty, and by making other improvements that will contribute to its efficiency and keep it abreast of the professional progress of the period. We have much pleasure in extending to Dr. Potter our sincere and hearty congratulations, and desire to express our heartfelt wish that both he and his journal may for many long years to come be successful and prosperous in every way. The Buffalo *Medical Journal* has for a long time been generally recognized as one of the best American medical monthly magazines. It scarcely needed anything in the way of improvement, and, consequently the new efforts in that direction are all the more creditable because there has been no demand for them. Success to Dr. Potter and his fifty-year-old medical journal!

PROFESSIONAL RELATIONS WITH CRIMINAL ABORTION.

THE recent arrest of two respectable physicians of New York, on the charge of being accessories in a case of criminal abortion, has naturally excited much interest among the members of the profession of that city. A special meeting of the Medical Society of the County of New York was held on March 16th, and the question was discussed in all its bearings. We publish in this issue a report (*N. Y. Medical Record*), which will probably be quite as interesting to Canadian physicians as to those of the United States.

Two respectable members of the profession, and of the "Society," had attended a woman suffering from septicæmia connected with abortion in the house of a midwife. The patient and the midwife both denied having done anything to induce the abortion, which they said was probably due to

over-exertion. On the advice of the physicians the patient was sent to a general hospital, where she died in a few hours. She, fortunately, made an ante-mortem statement, exonerating the doctors and incriminating the midwife. The hospital authorities informed the police as to the circumstances, and the two physicians were arrested on suspicion of having been engaged in a criminal act. After they were brought before the coroner, it was soon found that there was absolutely no evidence against them, and, at the same time, there was every reason to believe that they were perfectly innocent.

One of the questions which naturally arises in connection with such an unfortunate occurrence, and which became prominent in the discussion of the New York Medical Society, was the old one often asked before: How far is a physician justified in adhering to the good old rule that he is not to reveal any secrets acquired purely through his professional work? Dr. Irwin, it will be seen in the discussion referred to, stated positively that he would not report cases of abortion under any circumstances, as he did not consider that he was called on "to play the detective."

We have a good deal of sympathy with such views; but, at the same time, desire to utter a word of caution. The general practitioner—especially the young practitioner—who does anything which may appear in the eyes of the law like an attempt to conceal a crime assumes a very serious responsibility in any case; and more especially is this true when he attends a patient in a house not altogether above suspicion—and not her own home. The woman under treatment in New York had gone from her own home to the house of an "advertising" midwife; she was suffering from septicæmia connected with an abortion; "lifting heavy tubs" was said to have produced both the abortion and the septicæmia. *Heavy-tub* theories in cases with shady surroundings should not be considered in all respects satisfactory. Any physician who has nothing better to rely on under such circumstances should hardly feel surprised if he gets into rather serious trouble. In all doubtful cases, the doctor should get the assistance of a consultant or consultants (the best possible), or, perhaps better, consult a competent and respectable coroner.

THE ONTARIO MEDICAL ASSOCIATION.

AS announced in our last issue, the next meeting of this association will be held June 5th and 6th, in Toronto. The two committees who have the principal work as to arrangements in hand give us good reports as to the prospects, which are said to be bright. We are requested again to ask members who intend to read papers, especially those living outside of Toronto, to send word to the secretary, Dr. J. N. E. Brown, 186 King street west, Toronto, as soon as possible.

THE PATRON MEDICAL BILL.

DEBATE IN THE ONTARIO LEGISLATURE.

MR. HAYCOCK moved the second reading of a bill to amend the Medical Act. He said it had been asserted the object of the bill was to permit free trade in medicine. On the contrary, its provisions were just as stringent and afforded as much protection to the public as the present Act. The final examination held by the Medical Council was said to be for the purpose of protecting the public. That duty should rather devolve upon the Government, and not upon an irresponsible institution like the Medical Council. The bill provided for a Medical Examination Board and an examination that should be uniform throughout the medical schools. He contended that the Medical Council extorted an exorbitant sum in fees out of the pockets of the students, and in return gave them nothing but an interest in an "unprofitable bit of real estate on the corner of Bay street." The Discipline Committee of the Medical Council enjoyed powers such as no body of that kind should enjoy. A medical man could be deprived of his right to practise for what the Medical Council deemed "unprofessional conduct." Thus they were given the right to define crime. If a man was guilty of unbecoming conduct, he should be tried by the ordinary courts of the land, and not by a Star Chamber body of this kind. The bill proposed to define what was unbecoming conduct on the part of a medical man. Incidentally, the speaker said he had been informed there were doctors in Toronto who sold blank certificates at $12 a dozen to undertakers, and the latter filled in the cause of death themselves. The clause permitting midwives to be granted a certificate of competency after attending ten cases was not considered all-important. It was intended to apply to the outlying districts.

Mr. Stratton said if the bill were adopted it would be one of the most sweeping and injurious pieces of legislation that had ever passed the House. The Government had already enough to do, without assuming responsibility that now rested with the Medical Council. He criticized the leading provisions of the bill, and with respect to the change proposed in the amount of fees to be paid said no member would propose to suggest to the Grand Lodge of Patrons the amount of fee they should collect from subordinate lodges. The medical men were the best judges of the tariff

that should prevail. At present it afforded protection to the public. He protested against the adoption of any legislation calculated to weaken the standard of medical education. The bill was aimed directly at the medical profession, and he felt he should not be doing his duty unless he opposed it. He was quite satisfied that he would have the House with him in the amendment which he should move, seconded by Mr. Garrow, that the bill be not now read a second time, but that the order for a second reading be discharged.

Mr. Haycock immediately availed himself of the fact that the amendment put him in order, and spoke briefly in reply to Mr. Stratton. As for leaving the matter to the medical men, he said, they might as well wait till the manufacturers asked for a reduction of the protection given to them, or for the Senate to move for its own abolition. As for the statement that the legal profession has a similar control over its members, he replied that two wrongs do not make a right. Mr. Stratton's analogy between the medical tariff and the Patrons did not hold good; there would be some analogy if a law were proposed not allowing any man to practise farming unless he joined the Patrons. Mr. Haycock argued strongly on behalf of his bill, and concluded by seeking to move an amendment to the amendment to commit the bill to a special committee, but the Speaker ruled this out of order.

Sir Oliver Mowat said the bill appeared to him to be a bill which was not in the public interest, and which should not receive the approbation of the House. The medical profession was one of the most important of all the professions with which people had to do. It was a learned profession, and there was, he believed, no country in the world where it stood higher than in this province. It was an honorable profession, and in that respect it was, he thought, unsurpassed in any country in the world. The bill was revolutionary, and a strong case should be made out as to its necessity before the House should be induced to pass it. There were one or two features of it which he considered might be worthy of consideration, and perhaps the House might conclude to pass them. But it was the main principles of the bill which the House should look at. He agreed with the promoter of the bill that special legislation and special powers were given to the medical profession only for the better service of the public. He agreed, too, that the profession should be allowed to use them only so long as they were used for that purpose. Criticizing the bill, Sir Oliver replied to the statement that the fees paid by medical students upon entering their studies were too high. Without going into the details of whether they were or were not, he pointed out that at any rate they went to benefit the profession, and so eventually to the benefit of those who paid them. They did not go into some general fund belonging to the country, nor into some foreign fund, and they were appro-

priated by medical practitioners. The promoter of the bill had been specially severe in his criticism of the powers which the medical profession has of dealing with its own members. What were those powers? The fault or crime (to use the hon. member's words) which must be proved before a member can be stricken off the roll was something that amounts to a felony, something that amounts to a misdemeanor, or something that amounts to infamous or disgraceful conduct. Did the people of the province want felons practising among the medical profession, or men guilty of an offence which amounts to a misdemeanor, or of conduct which is infamous or disgraceful? Yet that must be shown before a name can be struck off the roll. The medical men were interested in purging their profession of that kind of persons. But since 1887 only nine cases out of the two or three thousand medical men had been tried under the authority which the profession have to try cases. Of these nine only four were convicted, and these only after repeated trials. And in these cases the evidence was so conclusive that only one ventured to avail himself of the power of appeal to a judge of the High Court. In this case the judge said that the offence was clearly proved, and he complimented the Medical Council upon the manner in which the case had been conducted.

Sir Oliver submitted that the whole case for the present bill broke down. There was no ground at all for a revolutionary proposal, no pretence that the power given to the medical profession had been abused, or that any one had been unfairly dealt with. There was, therefore, nothing to justify the House in supporting the bill, and he would, therefore, vote for the amendment. (Applause.)

Mr. Whitney supported the position taken by the Attorney-General, and in opposing the bill made a vigorous and free-handed attack upon the Patrons. He understood Mr. Haycock to wish to establish free trade in the practice of medicine. Mr. Haycock said he was opposed to class legislation, and yet he and those who acted with him owed their existence in that House to the class-legislation idea. Who had asked for the bill? No one, from Rat Portage to Glengarry. Last spring a squad of adventurers were let loose over the eastern portion of the province. They presided at oyster suppers with great unction, and grew sleek and fat. They told the farmers that the professions had special legislation, and that they were fattening upon the poor, down-trodden, and oppressed farmers. Occasionally they got people to believe them; and here now Mr. Haycock, not altogether master of himself, got up with this bill for fear these misguided people will call the instructors false prophets or something worse. The bill should be thrown out of the House without ceremony, and there had been times when bills like that were burned by the common hangman. (Laughter and applause.)

The vote was taken, and upon a vote of 15 to 71 the bill received the six months' hoist, only the Patrons as a body voting for it. Mr. McLean (Liberal) voted with them, while Messrs. Gurd (P.P.A.), Pardo (Patron), and Haggerty (Independent) voted with the majority.

Meetings of Medical Societies.

TRINITY MEDICAL ALUMNI ASSOCIATION.

THE third annual meeting of the above Association was held in Convocation Hall, Trinity University, April 4th. The attendance was large. The papers were interesting, but through lack of time those by Professor A. H. Ferguson, of Chicago, Ill., and Professor Roswell Park, of Buffalo, N.Y., were not discussed. Dr. George A. Bingham, of Toronto, presided.

SOME POINTS ON CEREBRO-SPINAL PATHOLOGY.

This was the title of a paper by Dr. Daniel Clark. He said that many morbid conditions of the body were due primarily to derangement of the nervous system. Too often the organic change, the result of the nerve lesion, received the practitioner's attention. The laws of repair operated upon the same principle in the nervous system as in other systems of the body. In treatment specifics were being replaced by therapeutic agents calculated to help the general system. Pathology had done much in advancing scientific principles of treatment. Much could be done by securing sanitary surroundings, administering nutritious food, attention to moral treatment; but it remained for the Master-builder to repair the waste places and to give tone to the flagging energies. The essayist pointed out the macroscopic and microscopic appearances to be seen in the brain and cord in various diseases of these structures, and also those seen in other organs of the body when at the same time abnormal conditions of the nerve tissue were observable, upon which these lesions in the other structures were probably dependent. Many of the dyspepsias were due to the existence of nerve derangements. The same could be said of Bright's disease, arterio-sclerosis, diabetes, spasmodic dysmenorrhœa, functional diseases of the heart, angina pectoris, and the various neuralgias. Puerperal mania was not always the result of sepsis, but eccentrically produced by impression on the cerebro-spinal system through the great sympathetic. The lesions in various skin, joint, and glandular affections were referred to nerve disturbances. The presence of amyloid material in the brain and cord was then referred to, and the retrograde metamor-

phoses which produced it pointed out. Syphilitic nerve lesions were discussed, and a contrasted view of the lesions in locomotor ataxia with those of paresis was given.

THE ANTITOXIN TREATMENT OF DIPHTHERIA.

Dr. Sheard took up this subject, demonstrating the various steps in the technique of obtaining cultures of the Klebs-Loeffler bacillus. He said the treatment of disease by antitoxins was not new. When germs were introduced into the body of an animal, they produced certain effete matter called toxine. In the blood of the animal the antitoxin was formed, which was an antidote to the toxine.

To get a culture, a smear should be taken from an infected throat and introduced into some medium, as gelatine, in which the organisms it contains will grow. They separate into different colonies—streptococci, staphylococci, etc., and the Klebs-Loeffler bacilli.

The doctor passed around tubes showing these various cultures, and pointed out the distinguishing features of the different colonies. A pure culture is made by placing some of the diphtheritic colony in bouillon, and allowing it to grow until the bouillon is saturated. By the old process this took three months; by the new about as many days, by the process introduced in France, of free aeration of the culture. (The apparatus for this was also shown.) Then, when saturation is complete, the separation of the germs is made by means of filtration through Pasteur's porcelain filter. (Filter presented for inspection.) The bouillon, which is aspirated through the porcelain vessel containing it into the surrounding vessel, contains no germs, and is injected in small quantities, repeated for some weeks, into the horse until no reactionary changes are seen in the horse; or, in other words, until he is immune. The horse's blood will now contain the antitoxin.

Dr. Sheard showed samples of three kinds of serum, and also the hypodermic syringe employed. The ordinary hypodermic needle was too small to use. This special syringe could be taken completely apart and sterilized. Absolute asepsis was, of course, necessary. The injection was made in the loin. It usually made a swelling about the size of a chestnut, but this disappeared in twenty minutes. He had not seen any serious local effects from its use. As it was harmless, an infant might be given as large a dose as an adult.

Dr. Sheard had used it in fifteen cases. These had been bacteriologically diagnosed. Statistics of antitoxin treatment would be misleading if this bacteriological examination were not made. The specific bacillus might be seen by examining a smear stained with methyl violet on a cover-glass preparation. But, if it could not be seen, then cultures should be made. The doctor showed tubes with probes tipped with sterilized cot-

ton, for the use of practitioners who wished to have examination made of smears from suspected throats. These would be examined gratis at the health department. The necessity of this examination of the membrane from the throats of patients sent to isolation hospitals was obvious. The distinctive features of the Klebs-Loeffler bacillus, as seen under the microscope, were pointed out. An easy means of differential diagnosis between the true bacillus and the pseudo was that cultures of the former would be found to be acid, of the latter alkaline. Of the fifteen cases, in three the diphtheritic bacillus was not found. In the twelve true cases the antitoxin was used seventy-two hours after the manifestation of the disease. There were five laryngeal, two tonsillar, the rest faucial and pharyngeal. Three of the laryngeal died. Mortality 25 per cent. The clinical phenomena following the treatment was then described. Recent German statistics given showed 11.1 per cent. mortality, a marked decrease over the old methods of treatment. But the speaker thought this might be attributed to the epidemic being milder. In those epidemics where the membranes examined showed the presence of the streptococcus longus, the mortality was very much more fatal than in those epidemics where this bacillus was not found. His opinion was that we are not yet in a position to pronounce upon the new treatment. In memory of their unsatisfactory experience with tuberculin, it would be unwise to decide as to its value until further investigation was made. Dr. Sheard extolled very highly the treatment of the disease (especially the laryngeal form) with fumigations of calomel, which method he described. Strong sprays of the bichloride of mercury (1-1000) were also highly commended. The peroxide of hydrogen was effectual in clearing out the pharynx and nasal passages, if filled up. But the membrane would rapidly form again. Alkalinized steam was helpful, as it counteracted the acid reaction of the toxin in the throat, and possibly lessened its virulence.

Drs. Price-Brown, Ernest Hall, and Pepler discussed the question.

Afternoon Session.

Dr. Joseph Price, of Philadelphia, presented a paper on

THE PHILOSOPHY OF ABDOMINAL AND PELVIC SURGERY.

The paper was a denunciation of surgical interference in pelvic disease from the vagina, which was coming into vogue in some quarters. He also attacked vigorously the resuscitation of the term pelvic cellulitis. Much error arose through the tendency many fell into of generalizing from isolated cases. Much of the paper was devoted to philosophizing on the necessity of having a proper conception of what had been done in the past, of accepting the good points and rejecting the bad; we should be proud of being successors of the brave pioneers that had pre-

ceded us. Wisdom was humble because she knew no more; knowledge was proud she had learned so much. Scientific emulation had too often been replaced by personal conflict, so that those who might have been agents of advancement became obstructionists. Such were those who resurrected pelvic cellulitis into the realm of pelvic pathology. The essayist deprecated the multiplicity of instruments for operation; the less paraphernalia the better. He also advised the strictest asepsis always. A person could not be spasmodically clean any more than he could be spasmodically pious. Adhesions were to be dealt with as they were found, and broken down with the finger only. All bleeding points should be carefully ligatured. In dirty cases the abdomen should be flooded. This was not only beneficial in cleansing, but was a powerful stimulant against shock. Drainage should be made through a glass tube, not by using gauze. The doctor closed his paper by referring to the judiciousness, care, and decision to be exercised for his success of operation and the welfare of the patient.

Dr. Temple said he would have preferred to have had Dr. Price discuss some specific operation; it would have opened up to him, at least, a better field for discussion. For many years Dr. Price had fearlessly declared the non-existence of pelvic cellulitis. He (the speaker) was not altogether a convert. That puerperal cellulitis did exist, he was quite satisfied in his own mind. He believed there were many diseases called cellulitis that were really pus tubes. He did not see how any surgeon could attack the abdominal cavity, knowing there might be large abscesses and many adhesions through the vagina. It could be reached by the abdominal incision much more easily. Of course, this did not apply to vaginal hysterectomy. Dr. Temple dwelt on other points brought out in the paper. He advocated the free use of soap and water for the hands of the operator and the assistants.

Dr. Kenneth Fenwick, of Kingston, said he believed there was such a thing as cellulitis. He had a case which threw some light on the subject—a case in which he had removed a pus tube a few months ago. The patient did well for three weeks. A tumor began to form in the region where the pus tube had been, similar to what one sees in parametritis after confinement. There was no doubt that pus was there. An opening was made by trochar through the vagina, and about two ounces of pus withdrawn. Dr. Fenwick considered that a case of cellulitis.

Dr. Price closed the discussion. Referring to his stress on asepsis, he said he did not wish to belittle the importance of antiseptics. But one operator had 122 amputations without a death. John Hunter did 158 ligations for aneurism without a death, before Lister was born. He spoke of the good results that came from operating in the morning. Operators who compared their mortality statistics found that morning operations

gave the best results. In the case of Dr. Fenwick the secondary trouble was due to ligature.

Dr. Price then spoke of fibroids. Somehow, he said, they behave badly nowadays—worse than years ago. They are not taking as good care of themselves as formerly. They slough and undergo retrograde changes, particularly during the last four years. The influenza, perhaps, had something to do with it—something, whether it is that or the faith cure. (Laughter.) He had found them slough, or undergo a sarcomatous change, even six or ten years after the menopause. Referring to the cellulitis again, he said: The character of inflammation differs. Compare that of a whitlow with that resulting from a post-mortem wound. Again, how much cellular tissue was there in the pelvis beside the small leaf of peritoneum of the broad ligament? He eulogized Emmet as an operator in plastic work. A man had no business to do this work until he sees Emmet. "Go and see him work. But," said Dr. Price, good-humoredly, "I don't think he knows much about pelvic work."

RADICAL CURE OF HERNIA.

This was the title of a paper by Professor A. H. Ferguson, of Chicago. He outlined the steps in the leading operations for the radical cure of hernia, pointed out their weak points, and then described his method, which combined the excellencies of the other methods, but contained none of their disadvantages. One reason so many operations for radical cure failed was because so little attention was paid to the pathology of the abdominal wall. In a study of the anatomy and pathology of the oblique inguinal variety there was first to be seen a dimpling at the internal ring, a congenital depression in the transversalis fascia at the origin of the cord at the union of the vas deferens and the vessels of the cord. As soon as this fascia was severed the hernial protrusion acted like a wedge, and the structures in the deep ring were forced asunder. The transversalis fascia in old cases was finally pushed downward, inward, and backward, until the lower border of the ring reaches the level of the pubic bone, forming an infundibuliform cavity. Operation should restore the deep ring to as small a size as possible without damage to the cord, and obliterate the funnel-shaped depression. McEwen was the first to recognize this. A second aim was to prevent relapses. He (McEwen) aimed at doing this by making use of the sac as a plug at the peritoneal aspect of the internal ring. He (the essayist) had found this sufficient where the internal ring was not large, nor the cord hypertrophied. But when the sac was small and the transversalis fascia at the deep ring much relaxed and low down, it (the sac) was not, he found, sufficient to fill the whole cavity at the seat of the rupture. But a small sac was better than none. McEwen

had done a post-mortem on a case where the rupture had been one of long standing. He found the canal was closed; the large sac of fibrous tissue made a cushion which prevented the chance of a return of the hernia.

A third pathological condition was the overstretched condition of the transversalis fascia behind the cord, easily demonstrated by raising the cord from its bed. A fourth condition found is an increase in the bulk of the veins of the cord. To Halstead was due the correction of that by removing some of them. There was no doubt, if left, the enlarged cord predisposed to relapse. The condition of the muscular aponeurosis was another important point. Constant pressure for years causes them to become thin and overstretched. They become blended, and it is difficult to differentiate them from one another or from the sac, with which they form a strong union. The conjoined tendon may be forced inward, and Poupart's ligament downward and outward. The deep epigastric artery may be obliterated.

These several pathological conditions, he held, were not rectified by any one of the later operations. In Bank's objections are: The sac is removed, the infundibulum is not obliterated, the transversalis fascia is not restored, the internal ring is not lessened, the cord is not reduced in size, the abdominal aponeuroses should be secured as firmly in front as behind, relapses are frequent. In McEwen's, the sac acts as a tampon, and obliterates the funnel-shaped depression, the canal is closed by bringing the external layer of structures with one suture to overlap the conjoined tendon on the inner and upper side. Objections: A new ring may not be formed by the suture closing the canal; the transversalis fascia is not restored behind. The spermatic cord is not reduced in size. The sutures closing the canal pass over the cord, and, if tied too tightly, endangers the vitality of the testicle. In McBurney's, the neck of the sac is ligated as high as possible. The skin is sutured to the deep fascia, and the wound packed with gauze. Objections: Sac is sacrificed; presence of scar tissue, which weakens with age. The density of the transversalis fascia is not restored. The pathological internal ring is not lessened in size. The cord is not reduced, when large. Relapses are frequent. He then pointed out the features in one or two other operations, and their defects.

Coming to Halstead's, he pointed out the various steps; in this the superfluous veins are removed. Objections: Sac is not utilized. The tightening of the six or eight sutures tends to cause internally a certain amount of concavity along the line of incision. The V-shaped depression where the cord leaves the abdomen is not guarded. There is too much cutting.

Referring to his plan, the essayist recommends an incision three or four inches in length, cutting through all the structures in front of the canal, without staining the tissues. It is not extended above the internal ring through the three abdominal muscles. The sac is then dissected out, and utilized after the mode of McEwen, occupying the position where the vas and the vessels meet. If there are too many veins, the excess are removed after Halstead. The slack, if it exists in the transversalis, is taken in one bite of the needle, being parallel to Poupart's ligament, another parallel to the conjoined tendon. This throws a ridge inward at the line of suture. The abdominal aponeurotic structures are sutured together. A number of sutures are taken, like in McEwen's, with one big suture, including these structures, so that when tightened there is overlapping of the external over the upper and internal.

The doctor then outlined the way he performed the radical cure in femoral hernia. The paper was accompanied by charts giving a comparative view of the different operations, and the phases of the method he employed.

Dr. Roswell Park read a paper on

INFECTION WITHIN THE CRANIUM.

The paper, which dealt with the subject in an elaborate manner, was cut short by the arrival of the hour for convocation. It dealt with the adjoining cavities as a source of infection, and their connection with brain cavity, and also with the various infective diseases of the membranes, and of the brain tissue, their pathology and symptomatology.

For lack of time there was no discussion of the last two papers.

TORONTO MEDICAL SOCIETY.

March 14th, 1895.

The president, Dr. Peters, in the chair.

EMPYEMA.

Dr. Williams, of West Toronto Junction, presented a patient upon whom he had operated for empyema. The child was aged eighteen months, and suffered from an attack of pneumonia in July last. It terminated in an empyema. During this attack the temperature ranged from 99° to 102°. There was dullness from the clavicle down to the base of the lung. The heart was displaced, the collection being in the left pleura. Aspiration revealed the nature of the contents. The incision was made in the ninth interspace, below the scapular angle. The pus was sweet

There was no washing out, nor special antiseptic precautions, as the surroundings were exceedingly unsanitary. A perfect recovery took place in two weeks.

Dr. N. A. Powell thought such a good result so soon was exceptional. He thought there would be some danger in operating so low down. The patency of the opening might be difficult to maintain, and the diaphragm might be in danger of injury in case of aspiration. He spoke highly of the use of creolin as a washing-out fluid in cases where the pus was non-laudable and irrigation was resorted to.

Dr. Geo. A. Peters pointed out that the diaphragm would likely be out of reach of the needle if the fluid were sufficient to press it down.

EXTRA-CAPSULAR FRACTURE.

Dr. C. Scadding reported the history of a case of extra-capsular fracture in an old woman aged ninety-two. No treatment was adopted but rest in bed. The old woman, being restless and mentally deficient, threw herself out of bed twice soon after the fall that occasioned the fracture, falling on the affected hip. However, after lying eight weeks, union took place.

Dr. F. Winnett, who did the post-mortem, presented the head of the femur, showing how union had taken place. The impaction was well shown. In most cases of this kind the great trochanter is fractured, but in this case it was not. There was also an absence of large processes of bone, which are invariably thrown out along the inter-trochanteric lines.

Dr. Williams said that the woman must have had a great deal of vitality, for at that age, with such a fracture and the necessity of keeping the recumbent position so long, there was a danger of her dying before union took place.

A PEDUNCULATED TUMOR.

A pedunculated tumor was presented by Dr. Powell, which he had removed from the gluteal region of a woman aged 65. It was superficial, pedunculated, and appeared like a fungating sarcomatous mass before removal, but on gross examination it appeared more of a fibrous character. He would present microscopic specimens at a later meeting, when the nature of the growth could be more positively ascertained.

MITRAL STENOSIS.

Dr. A. H. Garratt presented a heart showing mitral stenosis. He related briefly the history of the case. The woman suffered extremely from precardial pain and dyspnœa, despite everything he administered to relieve her. He had aspirated the peritoneum and the œdematous legs, withdrawing a quantity of fluid. There was no history of rheumatism in the case.

Dr. George A. Carveth said he had seen it stated that these cases do not die after exertion, as is commonly supposed, but after lying quietly in bed.

Dr. E. H. Adams said that, after following the history of a number of these cases, he had come to the conclusion that it was a wise thing to warn patients with heart disease to be careful as regards exercise; that their lives would be prolonged by so doing. He outlined the history of two of three cases he had observed.

Dr. A. H. Garratt said that he considered exercise a very necessary element in the treatment of such cases. The fresh air was very helpful to the respiratory functions.

Dr. R. J. Dwyer presented a heart showing a condition of mitral stenosis, with dilated and hypertrophied left auricle. Unlike Dr. Garratt's case, it caused absolutely no symptoms. The woman died from nephritis of the chronic interstitial variety, from which she had been suffering for eight years. He also showed the kidneys, which were large and red in color. The capsule was adherent. He outlined the symptoms. Another kidney was shown by Dr. Dwyer, showing the condition of parenchymatous nephritis. He also related the clinical history of this case.

March 21st, 1895.

The president, Dr. Peters, in the chair.

FRACTURE OF THE ULNA.

Dr. F. Winnett presented a patient who, while sparring, had fallen on the palm of his hand, fracturing the ulna at the junction of its upper and middle thirds and dislocating the radius head forward and upward. A right-angled splint was applied, and the dressing taken down at the end of twelve days. The dislocation had not improved. Under chloroform it was reduced, and the arm was put up in the straight position. It was now five weeks since the accident. The radius appeared to be dislocated forward at its head, as only partial flexion of the elbow could be made. There was also paralysis of the muscles supplied by the posterior interosseous nerve.

Dr. B. E. Mackenzie advised that these cases should be put up with the elbow flexed at an acute angle, the wrist being tied close to the neck. Authorities were generally agreed that this gave the best result. It had worked well where he had tried it. He was not in favor of any sort of splint that would restrict the circulation around the joint, such as plaster of Paris cases.

Dr. A. Primrose advocated the use of absorbent cotton splints after dislocations of the head of the radius, and firmly bandaged. The pressure would promote the absorption of the inflammatory material about the joint. The elbow could be perfectly flexed in this way.

AN ANALYSIS OF 6,777 CASES OF MIDWIFERY.

Dr. J. F. W. Ross gave an analysis of 6,777 cases of midwifery which his father had conducted. He referred to many interesting features connected with the cases. Although a busy practitioner, the late Dr. Ross kept a full account of all the important items connected with each case. The mortality of mothers was 39, the largest losses being from two epidemics of puerperal fever. The reader traced the disease in its course through each epidemic, and showed how careful his father was in regard to cleanliness and change of apparel in those pre-antiseptic days. He had made two runs of 650 cases without a death. There were 15 deaths from placenta prævia. There were 19 cases of version. There were 5,409 head presentations, 148 breech, 58 foot, 5 breech and foot, 25 face, 7 brow, and 34 arm and shoulder. Forceps were used 491 times. Latterly he had used them oftener, with a lessened mortality rate and a less number of lacerations of the perinæum. He believed the forceps properly used were conservative to the perineal body. Chloroform was used in 458 cases. There were 48 cases of retained placenta, and 27 perinea were torn.

Dr. A. H. Wright pointed out that in very many respects this was a phenomenal record. There were many lessons to be learned. One was that of cleanliness. Dr. Wright also spoke of the success that had attended Dr. Ross in his management of occipito-posterior positions of the head, and the ease with which he manipulated them into the anterior position. Another good lesson was the infrequent use of forceps. He believed in these latter days these were too often used. Another good example he set was in using chloroform so seldom.

Dr. H. Machell pointed out the excellent results as regards the mortality of mothers. That there were only 11 cases of eclampsia was also an astonishing part of the record.

Dr. Ross closed the discussion. He went carefully into his father's management of the cases in many points, showing how his good results had been attained.

It was moved that the society petition the Provincial Legislature to reject Bill No. 96, the Patrons' Medical Bill, which was aimed at hurting the profession. Carried.

TORONTO CLINICAL SOCIETY.

THE twenty second regular monthly meeting of the Toronto Clinical Society was held on Tuesday, March 12, 1895.

In the absence of the president, on motion Dr. Macfarlane took the chair.

The following Fellows were present: Walker, Cook, Anderson, Gregg, Powell, C. A. Temple, Macfarlane, Meyers, Brown, Bingham, Macdonald, Nattrass, Ryerson, Fotheringham, Trow.

The secretary read the minutes of the previous meeting, which were adopted.

PERICARDITIS.

Dr. N. A. Powell then related the following history of a case: Woman, aged fifty, always healthy till a year ago, when she suffered from an attack of la grippe, from which he understood she made but an imperfect recovery. She was ill about a week before he saw her with symptoms of grippe, some of the features of which were headache, cough, and general malaise. She recovered partly from this, went down stairs, sat in a draft, and returned to bed with increased bronchial symptoms, and sub-sternal pain. This was her condition when his first visit was made. Fearing the supervention of pneumonic or pleuritic trouble, he went over the chest pretty carefully. He did not think he would have missed a pericarditis if it had been present at that time, but it developed subsequently, while he was treating her. These cases were likely to be overlooked. It was related of a medical man who apologized to a celebrated consultant in London for having overlooked a case of pericarditis that the reply was: "Don't let that trouble you; if you had discovered it, you might have treated it" However, the speaker did not think the condition in the present case was due to the treatment. The patient had a normal temperature and pulse of 85 or 90 for two or three visits, and was doing apparently very well. Suddenly she was attacked with a pain in the left side. Going carefully over the side, he heard a to-and-fro friction rub, limited to the costal cartilage of the fourth rim on the left side of the sternum. This was heard close to the ear, and was heard when breathing was suspended. The pain was intense, and the action of the heart was tumultuous and rapid, reaching 120 or 125. The temperature rose to 102°. He saw her twice a day after that till the time of her death. After two or three days the pain was measurably relieved, but the action of the heart increased in rapidity to 140 or 150, and the dyspnœa became very marked. The heart became very irregular. There was not at any time, as far as he could recognize, any pericardial effusion. The diagnostic point of such effusion in limited amount, as Roach and others have emphasized, is the occurrence of dullness in the fifth interspace on the right side of the sternum, the normal heart projecting to the extent of one-half inch to the right of the sternum in the space. There was no increase of dullness there whatever. Being a spare woman, this could be marked out with reasonable accuracy. The pulse, after reaching its maximum rapidity, came down to 120, even less. It was very irregular from

minute to minute and intermittent. The bronchial trouble increased, but the cough was not accompanied by any mucous expectoration. The cough was progressive. The patient died from prostration, with signs of heart failure.

The interesting features of the case were:

(1) The causation of the trouble. It was well known that traumatism and Bright's disease are factors in its causation, and that the purulent forms often accompany Bright's; but pre-eminently it was met with in connection with rheumatic attacks. There were none of these causes present in this case. A sample of urine gave negative results. The only toxic element he could think of in connection with the case was grippa poison, whatever that might be.

(2) The absence of effusion. There were cases of pericarditis undoubtedly with formation of fibrin upon the surfaces, and it was notable in these cases that the friction sound was heard where the heart was closely hugged by the pericardial sac, not in its lower part, where the motion was at its maximum. There were cases of dry pericarditis, just as there were cases of dry pleurisy. There were cases with fibrin thrown out, and cases with serous effusion, and with purulent degeneration or purulency of that fluid *ab initio;* and a fourth form, the tubercular. This case, of course, was limited to the first.

Why did the woman die? Was it the pericarditis that killed her, or something else? It was to be remembered that she was a weakly woman, and there was an associated bronchitis. The best explanation that has been given in such cases of the cause of death is given by Bland Sutton. The cases where he (the speaker) had opportunity to examine the bodies after death bore out the statement. Where pericarditis did cause death, it was not from the pericarditis, but from associated myocarditis, not made out during life by physical examination so much as by the presence of dyspnœa. In this case the breathing did not fall below fifty. It even exceeded that number, even after the temperature and the pulse were hardly above normal. The marked dyspnœa was due to the extension of the inflammation along the fibrous tissue extending from the pericardium itself into the structure of the heart. The inflammation extends along the fibrous structures of the left heart, and in this way the nutrition of the heart is interfered with. In every case where death has followed pericarditis, the left heart has been found to be soft and flabby. Heart failure followed as a direct result, not from an inflammation of the covering, but of the walls. He did not know that it was necessary to speak of the treatment. The antirheumatic treatment was often resorted to, as rheumatism was so often an associated condition. Statistics proved that the least perturbating treatment produced the best results. He had had one other case in which the

diagnosis was very difficult. It belonged to that class of cases with which there is associated a limited amount of pleurisy, in which there is present at the time, or subsequently developed, a dry pleuritic friction sound limited to about the area where the pericardial friction sound would be heard. He did not think any one, no matter how expert, could make a diagnosis from physical examination alone. A study of subsequent events was necessary to clear up the uncertainty that might be present.

Dr. C. A. Temple: I would like to ask Dr. Powell if there was any lessening in the quantity of urine.

Dr. Anderson: I would like to ask Dr. Powell about what time the dyspnœa appeared. The pericarditis might have been due to some toxic element in the blood, and that same toxic element might have affected the heart muscle, which would be the cause of the dyspnœa. But, from the acuteness of the symptoms, I would be rather of the opinion that the inflammation of the heart muscle was due to an extension of the pericardial inflammation.

Dr. Powell: In answer to Dr. Temple, I might say there was a notable diminution in the quantity of the urine, particularly in the latter days of life. Coincident with the development of the inflammation, there was increased rapidity in breathing and accompanying pain. But, after the pain was relieved and the temperature had fallen and the pulse rate decreased, the dyspnœa still continued. The rapidity of the breathing was noticeable even when the patient was resting quietly and sleeping.

Dr. Macfarlane asked Dr. Anderson what form of toxic agent he considered the affection of the heart might be due to.

Dr. Anderson said that it might be secondary to Bright's disease, or, as Dr. Powell had said, due to the poison of la grippe. The dyspnœa might be accounted for by the action of the poison on the respiratory organs.

Dr. C. A. Temple then read a paper on the history of a case of pericarditis.

The case was one of pericarditis, with effusion, following an infected sore throat—a doubtful case of angina. The quantity of effusion was large; marked dyspnœa, and loss of voice; the amount of urine scanty; the febrile symptoms severe. Treatment was blister and syr. ferri iod.

Dr. Greig: There are one or two points in Dr. Temple's paper that call for remark. I could not help noticing the high temperature present. I think it was unusually high—104°. Under such circumstances one would expect to find pus. However, I suppose that can be ruled out, because, in children, if the nervous element is present, the temperature rises from slight causes. But in older persons, with a temperature of 104°, I would strongly suspect pus. I had a case of pericarditis with effusion two years ago, which was secondary to an attack of subacute rheumatism,

which was very well marked. The diagnosis of pericarditis was not difficult. There was a to-and-fro friction rub on the left side of the sternum. The effusion was excessive, causing dullness on the left side. If I had not heard the friction rub I would have suspected pleurisy. The case did well, and finally recovered.

The treatment I followed was the administration of the salicylate of soda, but I found that it inclined to depress the patient. The salicylates have a well-known tendency to deteriorate the blood; the patient was losing ground. As soon as I noticed this, I put the patient on iron, arsenic, and cod-liver oil and stimulants. As soon as the effects of these began to show themselves, recovery was rapid. During convalescence the girl was indiscreet, going out and getting her feet wet, a relapse following. She was sent to the hospital. I heard no more about the case.

Dr. Powell asked Dr. Greig a question: If, the friction rub having been heard in the early stage at the base of the heart, and the effusion subsequently becoming very large, he found it to be the case that the friction sound persisted throughout the existence of the effusion? Dr. Powell said that he had noticed in the last edition of Quain's dictionary the statement that, when once heard in this location, it did not disappear, no matter how much the effusion. He did not know of any other author who made the statement so positively. With regard to the iron used in these cases, it seemed to him that there were two forms especially useful. One was used largely by Loomis. He (Loomis) said it was nonsense—qualifying it with an expletive which he (the speaker) would not reproduce, but which was very emphatic—to give the syrup of the iodide of iron in any less quantity than a dram every three hours. Thus kept up, it produced rapid absorption. It should be given largely diluted. The other form was the ferri-salicylic acid mixture advised by Cohen, of Philadelphia. This combination was rather hard to make, but it was the only combination, according to Rice (one of the revisers of the Pharmacopœia), of these two drugs that could be given together.

Dr. Greig said that the friction rub did disappear during the effusion. It reappeared during the process of absorption. It was heard during the latter stages as distinctly as at first.

Dr. Fotheringham said that in the last case he had the double rub was heard until the patient had almost recovered. It was heard about half-way between the base and apex, at the left of the sternum.

Dr. Temple said that in his case he was a little troubled about the diagnosis at first, as the patient had slept with the one that had died from diphtheria four or five days previously. He was not sure whether the pericarditis was due to the diphtheria or the rheumatism. He gave salicylate of soda to relieve the pain, and, when this was relieved, administered the iodide of iron.

Dr. Macfarlane asked Dr. Temple if there were symptoms of rheumatic trouble.

Dr. Temple replied that the only symptom was pain in the knee-joint, but there was no pain or swelling, nor local heat.

Dr. Greig then detailed the history of a peculiar bladder case in a boy.

CASE FOR DIAGNOSIS.

He said: Mr. President and gentlemen, I have not a paper for you, but I think I can give you the points in the case as well without as with one. The case to me is rather interesting, and a little out of the usual line of such cases. About a month ago a lady brought to my office a boy, complaining that there was a large amount of deposit in his urine on standing for some time. He passed a sample for me, and it was very muddy in color and thick, very suggestive of pus. The reaction was intensely alkaline. The specific gravity was 1012. On filtering and making the reaction acid, I could not detect any albumin. Nor did it give the chemical reaction for pus, by the liquor potassa test. However, I could see pus cells under the microscope. There were no casts. The boy was aged twelve, not very robust, but appeared to be in good health. He went to school regularly, and was always ready for his meals. There was no constitutional diathesis, as far as I could make out. There was no tubercular history on either side. The peculiar feature of the case was that there was no frequency of micturition, nor increase in the quantity of urine passed. Nor was there any pain. He passed urine four or five times a day. Four years ago, when they were living in Winnipeg, he had symptoms of gravel. He was taken to a surgeon, who sounded him for stone. No stone was discovered. I might say that on examination of the urine under the microscope there was to be seen a profuse precipitation of triple phosphates, the most extensive display I ever saw. I sounded for stone three times, but I could not detect any. I have been treating him by washing out the bladder and administering internal remedies. Internally I have given boracic acid and salol, combined with tonics. The effect from this was not very satisfactory. I changed to the benzoates, giving first the benzoate of soda and afterward the benzoate of ammonia, combined with buchu. The effect not being satisfactory, I have been giving a preparation containing benzoic acid, buchu, uva ursa, and several other drugs. The drugs I have used for washing out the bladder were, first, boracic acid, acid 10 grains to the ounce. The effects of that appeared to be *nil*. It produced no pain. I found that a very large quantity could be injected with no discomfort, as much as twenty ounces, and the bladder was not full then. It appeared to be a very large amount to pass into the bladder, especially in a boy aged twelve. I next tried bichloride, 1-10,000; the result was beneficial in one way. The next

visit the urine was perfectly clear, and the reaction was not so intensely alkaline, but it caused him much pain. He could not sleep that night. I reduced the strength until he could bear it. But when it was diluted this much it seemed to lose its effect. I am now using permanganate of potash, 1 gr. to 1 oz. But this again produced a great deal of pain. I next used ½ a gr. to the oz., but this also produced pain. Last night I used ¼ gr. to the oz., and while the pain was not so great as before, yet it was considerable. The 1 gr. and the ½ gr. solutions caused a spasmodic action of the bladder. Its force was so great as to raise the fluid almost to the top of the funnel, when nearly empty. A spasmodic contraction of the rectum also took place. This was so violent that I was obliged to cease the washing while the boy went to the closet. The case is interesting in a good many ways. You would expect to find stone; and yet stone in children is easily diagnosed. You generally strike the stone immediately on introducing the sound. In this case I have manipulated most carefully, and can get no indication of stone. Nothing can be felt per rectum. The liver is normal. A fairly sized catheter can be passed without difficulty. If the permanganate is not successful in curing the case, I am going to try silver nitrate. However, it is so powerful that I am a little afraid to use it.

Dr. Macfarlane to Dr. Greig: What did they consult you about first?

Dr. Greig: The deposit in the urine. The boy was suffering no pain, there was no irritation, no frequency of micturition, simply a deposit of phosphates and pus.

Dr. Powell: I would like to ask a question and get Dr. O'Reilly to answer it. I know he has had a good deal of experience. Has any one any knowledge of the use of creolin as an irrigating fluid for the bladder? I have had some experience with it that makes me think it better than other remedies we have been using for this purpose. For example, in two recent cases of empyema I have used it after using saturated solutions of boracic acid. The pus discharged was extremely offensive and continued so, notwithstanding the use of boracic acid. The first injection of creolin, $\frac{1}{120}$, wiped away the odor completely, and it did not return. The case went on to recovery sooner than any I had seen before. Eight ounces of creolin have been swallowed by mistake and recovery followed. I suppose we have all used it in intra-uterine irrigation. Professor Shuttleworth has made experiments with regard to its efficiency as a germicide and antiseptic. He finds it one and a half times stronger than carbolic acid in similar strengths, quoting from memory. If its efficacy be greater than that of carbolic acid, and it be non-poisonous, it should be a proper fluid for irrigating the bladder. I have used for bladder irrigation silver nitrate solution. I am not surprised at $\frac{1}{500}$ permanganate

solution causing pain. My experience is that $\frac{1}{1000}$ or $\frac{1}{2000}$ is sufficient, and then increased gradually.

Dr. O'Reilly, being called on, said that he did not hear the paper, but was interested in the subject, as very many cases came under observation at the hospital.

Dr. Macdonald said the case was one in which a person would naturally look for stone as the cause of the trouble. The urine was apparently the urine of irritation, but it appeared on careful sounding that no stone was present. Even that did not exclude the possibility of stone being present. It might be there and be sacculated. It might be lodged in a pouch that was partly pervious, and yet miss the sound. There was one point that he had heard Dr. Greig refer to, and that was, there was an amount of residual urine. It had likely disappeared since the washing had been carried out. If there was a want of tone in the bladder, and residual urine was present, the case would resemble one of advanced prostatic disease. The question, however, was practically one of treatment, and Dr. Greig had certainly treated the case in a way that he (the speaker) would approve, by washing out the bladder with antiseptics. He had not yet tried turpentine. As this had the effect of changing the color to that of violets, he thought it worth trying. He did not know the manner Dr Greig had followed, but some were in the habit of injecting small injections slowly. His plan was to allow large amounts to flow in freely. He used the ordinary fountain syringe with a Y in the main tube leading to two branches, the one being clamped while the bladder was filling, then released, and the other one clamped while the bladder was emptying. (Dr. Macdonald here produced the apparatus for inspection.) At the end was an ordinary soft catheter. For women he used a glass catheter, and found it very satisfactory. He commonly used a much weaker solution of the permanganate and the bichloride than Dr. Greig had used. The bichloride was apt to produce considerable pain. A large injection would wash out the folds better than a small one. As to frequency, he would wash out two or three times a day at least. If this treatment did not effect a cure, the next thing would be cystotomy and drainage. It was easy to cut a hole in the bladder and drain, but such cases were not invariably successful, so he considered it wise to persevere with the washing out and the general systemic treatment for a considerable time before resorting to operation.

Dr. McFarlane said that he had listened with a great deal of interest to the report of the case. From what had been said he could not see that the symptoms were those of cystitis, as there were no subjective symptoms, there was no frequency of micturition, no increase in the quantity of urine, and no constitutional effects of the dis-

ease. With him, cystitis acted entirely differently, whether from stone, tubercle, or from whatever cause. Frequency of micturition was invariable. There was also a certain amount of restlessness on the part of the patient, especially at night, and then there were constitutional disturbances. The washing out with strong escharotics would do more harm than good, whether permanganate, bichloride, or silver nitrate. He did not think it wise to throw them into the bladder where there were no other symptoms than the presence of pus.

Dr. O'Reilly asked if Dr. Greig had used Stone's mixture, containing benzoic acid and carbonate of potash, internally.

Dr. Greig said that he had used benzoic acid and buchu. He had found a number of drugs that would purify the urine, but when he ceased using them the urine would again become foul.

Dr. Cook suggested that there might be some trouble in the pelvis or the kidney. He asked if there were any symptoms referable to the kidneys. He spoke of administering the urine by inhalation. This was useful in the case of children. One-half to two ounces might be used in this way during twenty-four hours.

Dr. Fotheringham asked if any of the Fellows had tried oxalic acid in small doses for these bladder cases. He had seen it act promptly in one or two cases. He had seen no rational explanation of its use.

Dr. Macfarlane asked if there was phimosis present.

Dr. Greig replied that there was some adherence of the prepuce, but not enough to account for symptoms. He stated that he had related the case at the Toronto Medical Society, and the impression of the members was that it was a case of stone, but the authorities stated that stone in children was easily recognized. There was one peculiar point, and that was on the sound entering the bladder it always had a tendency to fall to the left side. He was not able to bring it to the right side at all. He did not know if that indicated any malformation of the bladder, but it suggested it.

He had not tried oxalic acid. He had thought of trying creolin, but as he had never heard of its being used he did not like to initiate the treatment. In regard to Dr. Macdonald's plan, he thought there was danger of too much force being brought to bear on the walls of the bladder.

Dr. Macdonald said that by raising or lowering the bag any degree of force could be obtained.

Dr. Greig, continuing, said that he followed Skene's method of washing out the bladder. He stated that in this case he could not use a large catheter, so that irrigation was necessarily slow. He pointed out that the amount of residual urine amounted to about two ounces, which he withdrew with the catheter. He had asked the patient to pass his water while

on the hands and knees, so that the bladder would be more completely emptied. As the urine was alkaline he thought there was no kidney trouble, unless the cystitis accompanied the pyelitis.

Dr. Trow then read the report of a case of a foreign body in the œsophagus.

Dr. Powell related the history of a case in which a fish-hook had been swallowed. A boy, upon his return home from a fishing expedition, found his grandmother asleep with her mouth open. The temptation being great, he dropped his baited hook into the old lady's mouth. Awaking with a start and a swallow down went the hook, with the string attached. A young physician who had just settled in the place was hastily summoned. He asked the boy for another of his hooks, took a bullet from his pocket, made a hole through it so that it would fit over the hook, then he threaded it on the line, and with a catheter pushed it down, so that it slid over the hook in the stomach, which was then withdrawn without injury to the walls of the stomach or œsophagus.

Dr. Bingham presented a double-headed monster which he had recently taken from a woman.

The meeting then adjourned.

Book Reviews.

A Book of Detachable Diet Lists, for Albuminuria, Anæmia and Debility, Constipation, Diabetes, Diarrhœa, Dyspepsia, Fevers, Gout or Uric Acid Diathesis, Obesity, Tuberculosis, and a Sick-Room Dietary. Compiled by Jerome B. Thomas, A.B., M.D., visiting physician to the Home for Friendless Women and Children and to the Newsboys' Home ; assistant visiting physician to the King's County Hospital ; assistant bacteriologist Brooklyn Health Department. Price, $1.50. Philadelphia : W. B. Saunders, 925 Walnut street.

Between the covers of this book are printed the diet lists for many diseases. These can be torn out and further enlarged to suit the practitioner's requirements and left with the nurse in charge. As complete directions for making soups, egg-nog, and many delicacies are printed, there can be no excuse for not following out instructions. We can recommend them to the profession.

Enlargement of the Prostate : Its Treatment and Radical Cure. By C. W. Mansell-Moulein, M.A., M.D. Oxon., F.R.C.S., etc. Demy 8vo. 176 pages. Price, $1.50. London : H. K. Lewis, 136 Gower street, W.C.

The above volume is filled with information, presented in a most instructive and readable manner. The first chapter deals with the Normal Prostate, its size, development, relations, and functions. It points out clearly a mistaken idea in reference to the homology between prostate and uterus. "The uterus, therefore, is homologous with part of the prostatic *utricle*, and in no way with the prostatic gland." The homology, therefore, that is daily made between uterine fibroids and prostatic enlargement is based on error.

The succeeding four chapters consider the prostate undergoing pathological change, and the causes and effects thereof.

The sixth chapter is very complete, and deals with the most important subject, Diagnosis. Too much care cannot be devoted to the subject of diagnosis. Every male of fifty years of age is not suffering from enlarged prostate, and urinary disorders can arise in them from other causes. The operative treatment is ably discussed, while local treatment by the catheter to maintain the urethral capacity, prevention of cystitis and retention, etc., etc., are all referred to.

Chapter eleven, where the subject of Castration for the cure of Enlarged Prostate is dealt with, is up to date. We are surprised, though, to notice that due credit is not given to Dr. J. William White for priority in this field, more especially since the author lays claim to the idea, as follows : "As frequently happens in such cases, the same idea appears to have occurred, more or less defi-

nitely, to many people almost at the same time. In November, 1892, shortly after the publication of my Hunterian lectures, I discovered the advisability of the operation with a patient who, though he admitted the force of the arguments in favor of it, not unnaturally declined it on the ground that it must be in the nature of an experiment." This is altogether too flimsy an argument on which to base any claim to priority of idea. The credit is clearly due to Dr. White, and has been pretty well acknowledged by the author's own countrymen.

The last chapter, on Conclusion, is very trite, and concisely sums up the question. We can thoroughly recommend the work to the profession as being the best work on "Enlargement of the Prostate" printed in English to-day. The illustrations, typography, paper, and binding are, as usual with Mr. Lewis' publications, first class.

Books and pamphlets received :

THE PHYSIOLOGY OF THE CARBOHYDRATES. Their application as Food and relation to Diabetes. By F. W. Pavy, M.D., LL.D., F.R.S., F.R.C.P., etc. 280 pages. Illustrated, $2.50. London : J. A. Churchill.

THE YEAR BOOK OF TREATMENT FOR 1895. A Comprehensive and Critical Review for Practitioners of Medicine and Surgery. In one 12mo. volume of 501 pages. Cloth, $1.50. Philadelphia : Lea Brothers & Co., 1895.

INTERNATIONAL MEDICAL ANNUAL FOR 1895. A concise, well arranged, practical and helpful volume, giving the advance of medical science in all parts of the world. 648 pages. Illustrated. Price, $2.75. New York : E. B. Treat.

A NEW METHOD OF EXAMINATION AND TREATMENT OF DISEASES OF THE RECTUM AND SIGMOID FLEXURE. By Howard A. Kelly, M.D., of Baltimore, Professor of Gynæcology and Obstetrics in the Johns Hopkins University.

THE TREATMENT OF WOUNDS, ULCERS, AND ABSCESSES. By W. Watson Cheyne, M.B., F.R.S., F.R.C.S., Professor of Surgery in King's College, London. In one 12mo. volume of 207 pages. Cloth, $1.25. Philadelphia : Lea Bros. & Co., 1895.

SAUNDERS' NEW AID SERIES. A manual of the modern theory and technique of surgical asepsis. By Carl Beck, M.D., New York. 65 illustrations and 12 full-page plates ; 306 pages. Price, $1.25. Philadelphia : W. B. Saunders, 925 Walnut street.

MEDICAL NURSERY. Notes on lectures given to the Probationers at the London Hospital. By James Anderson, M.D., F.R.C.P., etc., etc. Edited by Ethel F. Lamport, with an introductory Biographical notice by Sir Andrew Clark, Bart. 184 pages. London : H. K. Lewis, 136 Gower Street, W.C.

A SYSTEM OF SURGERY.—Messrs. Lea Brothers & Co., of Philadelphia, announce the publication of a new System of Surgery by American authors, edited by Frederic S. Dennis, M.D., of Bellevue Hospital Medical College, New York. It will be completed in four imperial octavo volumes, containing about 900 pages each, and illustrated with figures in colors and in black. It is expected that the first volume will be ready some time this month, and that the succeeding volumes will follow at short intervals

Medical Items.

THE wife of Dr. F. C. Heath died suddenly in Brantford on Sunday, March 31st.

PROF. OSLER, of Johns Hopkins Hospital, Baltimore, spent a couple of days in Toronto at Easter time.

DR. GEORGE STERLING RYERSON, M.P.P., of Toronto, has been promoted to the rank of Deputy Surgeon-General.

DR. L. F. BARKER (Tor., '90), who has been at Johns Hopkins for the last four years, sailed March 20th for the continent, where he will remain about six months.

AT a meeting of the Canadian Wheelmen's Association held in Toronto, April 12th, Dr. P. E. Doolittle, of Toronto, was elected president, and Dr. J. D. Balfour, of London, vice-president.

ROOSEVELT HOSPITAL, New York, is to be enlarged by the addition of a five-story building to the west wing ; the estimated cost is $125,000.

IT is proposed to erect a ten-story building in Chicago, to be called "The Medical," the offices of which will be rented exclusively to doctors. The rooms and conveniences will be arranged to suit the views of both doctors and patients.

THE next International Congress of Gynæcology and Obstetrics meets at Geneva in September, 1895. It will discuss the subjects of Eclampsia, Displacements of the Uterus, Pelvic Contractions, Pelvic Suppurations, and Abdominal Sutures.

A STATUE FOR DR. GROSS.—A joint resolution, permitting a bronze statue to be erected on public grounds in Washington in honor of Dr. Samuel D. Gross, and appropriating $1,500 for preparation of the site, was reported from the Library Committee in the Senate, and passed.

ANOTHER CONSUMPTIVES' HOME.—Mr. J. H. Schiff and Mr. L. G. Bloomingdale have each given $25,000 for the establishment of a country home for consumptives. The new establishment will be called the Montefiore Country Home for Consumptives. It will be non-sectarian, and entirely devoted to the poor.—*Medical Record.*

ANOTHER HOME FOR CONSUMPTIVES.—General J. Watts De Peyster, of Red Hook, has had plans drawn for a Consumptives' Home at Verbank, N.Y., which will cost $30,000, and accommodate three hundred patients. It

will be the second institution of its character in New York State. The construction of the building will be begun as soon as the necessary details can be carried out.—*Medical Record.*

AS OTHERS SEE US.—"The other day I heard an apophthegm," writes Mr. James Payn, "which left me with a very exalted idea of the gentleman who uttered it. We were talking of the medical profession, and he observed of it: 'There is a great difference between a good doctor and a bad one, but very little between a good doctor and none at all.' The cynicism of the remark was deplorable, but its intelligence was indisputable."

THE Philadelphia Board of Charities and Correction has appointed Dr. Hobart A. Hare a member of the staff of physicians at the Philadelphia Hospital, in place of Dr. Judson Daland, who has been dropped. The reason given for this action on the part of the board is that Dr. Daland is alleged to have allowed certain patients suffering from malaria to go untreated for a certain length of time, in order that he might study the development of the peculiar organism which produces malaria. To a board capable of such action for such reasons it probably makes very little difference what criticisms may be made upon its action, but we think it likely that the medical profession and the medical press will not rest content without knowing more and saying something about such a policy.—*Boston Medical and Surgical Journal.*

A SHOT AT A WILD DUCK.—Was ever shot at a wild duck so fateful to men and empires as this? A father and his son were hunting wild fowl on a northern marsh. The young man shot at a duck, dropped it, and hurried to gather it. Reaching the spot where it had fallen, he found himself in an oozy treacherous slime, into which he began rapidly to sink. In response to his son's cries of alarm, the father hastened to the rescue, and, being a man of prodigious strength, succeeded in extricating him, but not before he himself had become thoroughly wet through. The two duck hunters hastened home. That home was the palace of Spala. The father was Alexander III., Czar of Russia, the son was the Grand Duke George. From the chill that resulted from the exposure undergone in saving his son from the duck bog was developed that malady which ended in the death of the Czar. Thus the fortunes of a dynasty were changed by a chance shot at a wild duck on the marsh. Was ever such a shot at a duck before or since?—*Forest and Stream.*

THE NEW YORK CITY BOARD OF HEALTH AND SPURIOUS ANTITOXIN.—The Board of Health has adopted the following resolution:

"That no preparation of diphtheria antitoxin shall be offered or exposed for sale in this city unless the receptacle containing such preparation has a label on which is placed a statement of the value of the contents in antitoxin, as measured by some generally recognized standard, and the name and address of the producer."

No one doubts that this resolution is in the interests of public health. But it is a curious fact that such a resolution is allowed to pass unnoticed by the advocates of personal liberty. The newspapers advertise, and drug stores

display, any number of spurious cures for cancer, consumption, epilepsy, etc., and no one protests. But the sale of a spurious cure for diphtheria is forbidden.—*N. Y. Medical Record.*

THE ART OF NURSING.—The second annual meeting of the American Society of Superintendents of Training Schools met in Boston, Mass., at "The Thorndike," on Wednesday and Thursday, February 13th and 14th, the following Canadian Training Schools being represented: Miss Snively, superintendent Training School, Toronto General Hospital; Miss Draper, Royal Victoria Hospital, Montreal; Miss Moore, Lady Stanley Institute, Ottawa; Miss Brent, Homœopathic Hospital, Toronto; and Miss Underhill, Children's Hospital, Toronto. During the convention many valuable papers were read by the members present, and most interesting and lively discussions followed. The organization, although young, is certainly vigorous, and gives promise of much good work in advancing the interests of the nursing profession. Miss Snively read a paper on "A Uniform Curriculum for Training Schools," and was granted a committee to aid her in drafting a suitable curriculum, to be presented at the next annual convention, in order that in the near future some definite steps could be taken in this important direction. The social element was a pleasant feature of the gathering, the members of the convention being entertained at several lunches and receptions, one of the most pleasant of the latter being that given by the superintendent and trustees of the Boston City Hospital. The administration building and library of the hospital were thrown open, the rooms brilliantly lighted and decorated, and a large number of the prominent medical men and distinguished citizens were present. The next annual meeting will be held in Philadelphia. The following officers were elected for the ensuing year: Miss Davis, University Hospital, Philadelphia, president; Miss Snively, Toronto General Hospital, vice-president; Miss Drown, City Hospital, Boston, treasurer; Miss Littlefield, Episcopal Hospital, Philadelphia, secretary; Miss Darche, Charity Hospital, New York, and Miss Richards, Episcopal Hospital, Brooklyn, councillors.—*The Mail and Empire.*

DEATH RATE AMONG MEDICAL MEN.—The death rate which prevails among medical men has often been the subject of inquiry. The curiosity felt by the public on the point has been probably not unmixed with the ironical spirit with which the world learnt that a late Lord Chancellor had drawn his own will amiss. But even a cursory examination of the statistics hitherto presented convinces us that no very valuable conclusions can yet be drawn in so complicated a matter. The usual fallacy of casual deductions from statistical data presents itself at once. General practitioners are no doubt exposed to peculiar dangers of infection and contagion, which probably shorten their average life. But to impute to the profession itself—apart from such special dangers—any considerable importance in determining the duration of life is impossible in present circumstances. We know little or nothing of the averages of deaths from various causes which prevail amongst those who follow other professions. Bertillon's comparison of the mean duration of life in the medical

profession and among quarrymen bristles with fallacious implications. How can we compare an occupation which needs great physical vigor with a professional life? A quarryman must abandon his work if he is enfeebled, and will drift into other employments. Nevertheless, these paragraphs which we lately met with do possess a general interest. Dr. Salzmann, of Essling, in Würtemburg, has been investigating the mean duration of life in German medical men during the last four centuries. The sixteenth century showed average death at the age of thirty-six years; in the next hundred years life was usually prolonged to forty-five; forty-nine was usually reached in the eighteenth; and in our own times fifty-six years. The marked improvement he attributes to the decreasing virulence of plague, smallpox, and typhus. An abnormally high death rate from tuberculosis is reported to exist among medical men in Russia—15 per cent. of the whole number of deaths being assignable to that cause. Zelande has lately presented some most valuable statistics, calculated for three years, upon a consideration of the whole profession, some 15,000 odd. Nearly 33 per cent. of deaths were due to virulent diseases—pyæmia, typhus, cholera, diphtheria, etc. The prevalence of suicide, over 8 per cent., too, is strange. The *Medical Press* suggests poverty as a possible cause for this self-destruction; and in harmony with such an inference is the French experience that a large majority of suicides is due to want or fear of want. Perhaps the most satisfactory feature in the statistics we have seen is the statement of Bertillon, that though medical men do not apparently enjoy longer life than many others, their children display a singular immunity from disease.—*The Medical Magazine*, London.

PARASITISM, SYMBIOSIS, AND COMMENSALISM—When one organism lives in or upon another, and feeds at that other's expense, as an unbidden guest, without benefiting its host in any way, we call the condition parasitism. But there are many cases where the two beings form a physiological partnership, and these are generally included under the name symbiosis. The members of the firm may be both animals, or both plants, or one may be an animal and the other a plant. In some the association is so close that it is exceedingly difficult to determine that they are indeed two beings and not one. For many years, for example, in some radiolarians little yellow bodies had been noticed. They were seen to possess a well-defined nucleus and a cell-wall, and they were looked upon at one time as spores, at another as secretory cells; but later it was found that, though the radiolarian might die, yet the yellow bodies would survive and multiply. They were, in fact, minute algæ, and, though they lived in the radiolarian, the host and the guests both prospered; for the host gave off carbonic acid and nitrogenous products, which formed the best food for his guests, the algæ; and these in their turn evolved oxygen, and so supplied one of the chief wants of the radiolarian. Each profited by the association. In other cases the union is much less intimate, and these have been differentiated by name under the term Commensalism. There is a hermit crab who carries about with him attached to his shell, or even to his claw, a sea-anemone When the crab feeds the anemone shares the feast, and, moreover, enjoys the

benefits of free locomotion, though little able to move itself. In its turn it serves to protect the crab by hiding him, and may also aid in killing or numbing his prey; and when the time comes that the crab must seek a new shell, he carefully assists his partner to change his home, also showing how greatly he appreciates the union. To other examples of this sort of partnership we have referred elsewhere in an account of the additions which have been made to the museum of the Royal College of Surgeons of England during the past year. An acacia tree finds itself in danger of destruction by ants and other insects, and enlists in its service a tribe of ants, who are not only innocuous, but ready to fight for the plant and keep off its foes. But the ants are true mercenaries, and will not serve without pay, and for them the tree provides food and shelter—hollow appendages (stipules) to live in, and nutrient fluids on which they may feed. Then, when the foes appear, they rush out and drive them off. The allied phenomena of parasitism, symbiosis, and commensalism illustrate in a marked manner the interdependence of organisms, and bring home to us in a picturesque manner the fact that few are able to live only for and by themselves, but that it is the common lot by serving others to serve ourselves.—*The Lancet.*

OBITUARY.

DANIEL HACK TUKE, M.D., LL.D., F.R.C.P.—Dr. Hack Tuke, the great alienist of England—probably the greatest in the world—died March 6th, at the age of sixty-eight.

E. D. WORTHINGTON, M.A., M.D.—We learn from the *Montreal Medical Journal* of March that Dr. E. D. Worthington, one of the oldest and most highly respected practitioners in the Province of Quebec, is dead. He was seventy-five years of age. He practised about 50 years in Sherbrooke.

KENNETH HUGH L. CAMERON, M.D.—We have to announce with deep regret the death of Dr. K. H. L. Cameron, M.D., at his late residence, Cayuga, on the morning of April 8th, in the forty-first year of his age. He was a student of the Toronto School for four years, and received the degree of M.B. from the University of Toronto in 1875; also M.D. in 1876. After graduating he commenced practice in Cayuga, where he remained until the time of his death. He was successful and highly respected both as a physician and a citizen.

SIR WILLIAM SCOVELL SAVORY, BART.—Mr. Savory, the distinguished surgeon of St. Bartholomew's Hospital, London, died after a short illness from influenza, March 4th, at the age of 69. He was very conservative, and, at the same time, brilliant in many respects; and, although he did not write much, was generally regarded in Great Britain and on the continent as one of the greatest surgeons of the age. *The British Medical Journal*, in an obituary notice, refers to a very pathetic incident in his life. In 1867 his finger was poisoned, and the septic process was transmitted to his wife, who dressed the injured hand. Mr. Savory recovered after a prolonged illness, but Mrs. Savory died.