

## Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /  
Couverture de couleur
- Covers damaged /  
Couverture endommagée
- Covers restored and/or laminated /  
Couverture restaurée et/ou pelliculée
- Cover title missing /  
Le titre de couverture manque
- Coloured maps /  
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /  
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /  
Planches et/ou illustrations en couleur
- Bound with other material /  
Relié avec d'autres documents
- Only edition available /  
Seule édition disponible
- Tight binding may cause shadows or distortion  
along interior margin / La reliure serrée peut  
causer de l'ombre ou de la distorsion le long de la  
marge intérieure.
- Additional comments /  
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /  
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/  
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /  
Qualité inégale de l'impression
- Includes supplementary materials /  
Comprend du matériel supplémentaire
- Blank leaves added during restorations may  
appear within the text. Whenever possible, these  
have been omitted from scanning / Il se peut que  
certaines pages blanches ajoutées lors d'une  
restauration apparaissent dans le texte, mais,  
lorsque cela était possible, ces pages n'ont pas  
été numérisées.

# CANADA

## MEDICAL & SURGICAL JOURNAL

SEPTEMBER, 1885.

Original Communications.

### MELANOTIC FIBRO-SARCOMA OF ORBIT REMOVED TEN YEARS AFTER ENUCLEATION OF THE EYEBALL CONTAINING A PIGMENTED GROWTH.\*

By F. BULLER, M.D., M.R.C.S., ENG.,

Professor of Ophthalmology and Otology, McGill University, Montreal.

On the 27th day of May of the current year Mrs. X., aged 48, came to me for advice on account of a painful affection of the right orbit, which for a number of years had been causing her a great deal of discomfort and annoyance. The history of the case, as given in a communication from her medical attendant, is as follows:—

“ About the year 1863 or 1864 Mrs. X. accidentally noticed  
“ she was minus the sight of the right eye. The pupil was  
“ dilated, but did not present the appearance seen in fungus  
“ hæmatodes or encephaloid of the eye. At this time the optic  
“ nerve must have been affected. On ophthalmoscopic exami-  
“ nation I discovered no disease of notice.

“ About the year 1865 she suffered from severe pains in the  
“ region of this eyeball, which would shoot and extend from the  
“ occiput of the same side to the eye, or from the eye to the  
“ occiput. About the year 1868 she suffered from an exceed-  
“ ingly severe attack of inflammation of the nervous apparatus,

---

\* Read before the American Ophthalmological Society at New London, Conn., July 15, 1885.

“eyeball and eyelids, and there were recurring attacks of  
“inflammatory and neuralgic conditions of the lids, eye, etc.,  
“till about the year 1872 or 1873, when the other eye began  
“to be affected as I thought through sympathy. This sympa-  
“thetic affection continued with remissions and exacerbations  
“until it was evident the left eye, too, would be totally des-  
“troyed. I therefore advised the removal of the right eye,  
“which during all this time was giving her a great deal of  
“pain. She finally consented to the operation, which was  
“done by the late Dr. Robertson, of Albany, in 1874.

“On cutting into the eyeball, after its removal, the vitreous  
“humor was quite dense, not like cartilage and not solid; it  
“was dark,—if I rightly remember it was black—and contained  
“several speculæ of bone, some of which were sharp-pointed.  
“I preserved for a long time one of these bones, which was  
“one-quarter inch or more in length; and this reminds me that  
“for a year or two she had complained of a pricking sensation  
“in the eyeball, caused, no doubt, by these sharp points.

“She made a good recovery from the operation, and the  
“sympathetic trouble in the other eye subsided.

“After two or three years the same pains and recurring  
“inflammatory affections of the tissues of the lids and orbit  
“reappeared, and have persisted more or less ever since.  
“Three or four years ago the orbit began to fill up. Two  
“years ago next autumn it was about filled; she then had an  
“exceedingly severe time, with pain and inflammation of the  
“surrounding tissues in close proximity to the orbit. The  
“swelling in the orbit burst, and then subsided very much, but  
“in a few months began to increase again.”

The remainder of the communication, dealing with the family history of the patient, contained nothing of importance. In some points the patient's own statements differ materially from those of her physician. She states that about a year after the loss of vision was first noticed the eye swelled up and burst, and then shrank; for some time afterwards she wore an artificial eye, but had to abandon its use owing to the discomfort it caused. That pain in the orbit and head returned within a

year after the removal of the diseased eye, and were usually most troublesome during the early part of the night, though sometimes she could hardly get any sleep all night long on this account. Often, after suffering for some hours, sudden relief would occur with a copious flow of tears from the conjunctival sac; that the inflammatory swelling which occurred two years ago subsided without any discharge other than a watery fluid.

In the absence of a minute examination of the diseased eyeball after its removal, the nature of the case cannot, of course, be positively asserted, though there is strong reason to believe the eyeball was filled with a pigmented sarcomatous growth at the time of its removal ten years ago.

The left eye is entirely normal, and shows no trace of sympathetic trouble.

Mrs. X. does not appear to have suffered in her general health, and presents no sign of functional or organic disorder other than that within the orbit.

The eyelids on the affected side are slightly swollen and darker than on the other side, and there is some lachrymation from the empty conjunctival sac, but the conjunctiva is perfectly healthy. *Only in the centre of the sac there is a small area of a darker color than elsewhere, traversed by a few dark, tortuous veins.* Here, too, the conjunctiva rests upon a firm mass, which is not subject to even a trace of muscular movement.

The orbit is in fact two-thirds filled by a firm, somewhat nodular mass, not adherent to its walls at the periphery, but not moveable to any extent. Pressure on the mass from below upwards causes pain, but not from above downwards. There is nowhere the least suspicion of fluctuation. Without forming a positive opinion as to the nature of the growth, though the dark patch over its central position was strongly suggestive of its pigmented character, I advised its removal with a view of relieving the almost constant pain caused apparently by its presence. To this the patient readily consented. The tumor was removed June 3rd. In order to have plenty of room I divided the outer canthus, then dissected back the healthy con-

conjunctiva ; with curved scissors and the fingers I removed first an isolated ovoid mass, of a dark color, enclosed in a delicate capsule and having a somewhat lobulated surface ; this mass— $2\frac{1}{2}$  cm. in length, 2 cm. wide and 1 cm. in thickness—was quite firm in texture. After its removal, the apex of the orbit was found to be occupied by a considerable quantity of softer material, which was cleared out with the curved scissors as completely as possible, and when the moderate bleeding had ceased chloride of zinc paste applied to the deep portion of the orbit in the usual way. The patient made a satisfactory recovery and returned home at the end of a week. As yet (July 15) there is no return of the growth, though, of course, too soon to expect any such result ; but she remains free from pain, and in so far success has been achieved by the operation.

The ovoid mass first removed showed on section a mottled appearance, being divided into lobules of a dark color and irregular as to size and shape by broad bands of pale, fibrous tissue. The central portion of the lobules was made up almost entirely of cellular elements, but even here in thin sections, logwood staining brought out a delicate linear meshwork of white fibrous tissue, so arranged as to give the cells the appearance of being placed in rows in its long meshes.

In parts the cells were nearly all crowded with granules of a golden brown or black pigment, which for the most part was uniformly distributed in the cell plasma ; very few had more than one nucleus, which was always remarkably distinct. In certain localities pigmented and non-pigmented cells were present in about equal proportion, and in others none were pigmented.

Throughout the growth the prevailing character of the cells was spindle-shaped with long processes, or oat-shaped, though round cells were not wanting in any of the cellular parts, and in places were in excess of the others. Multipolar cells were extremely rare, though not entirely wanting.

As a general thing the non-pigmented cells were smaller than the pigmented, though otherwise precisely similar in character and arrangement.

The pale portions of the tumor consisted almost exclusively of white fibrous tissue, the same is true of its capsular envelope; yellow elastic fibres were also present in the peripheral parts of the fibrous intersections of the growth. The tumor was by no means a very vascular one, though traversed by a network of delicate capillaries. The larger blood vessels were characterized by their very thick walls and relatively narrow lumen—a circumstance which may in some measure serve to account for the slow development of the tumor; extravasated blood corpuscles were present in small areas here and there, and in some places extra cellular deposits of granular pigments, probably of hæmorrhagic origin. The softer, posterior, deep-seated portion of the mass in the orbit was of a dull red color, very friable and almost pulpy in consistence.

Portions of this, treated in the same manner as the preceding, were seen to consist almost entirely of small round cells interspersed with numerous extravasations of blood; in some places blood corpuscles and tumor cells were found mingled in almost equal proportions. The cells contained very large nuclei; possibly many of these were free nuclei, at least they had that appearance. In a few places similar small round cells were charged with a brown pigment granules, but as this always occurred at or in the vicinity of blood extravasations and in association with considerable quantities of free pigment, there is some doubt as to origin in the cells containing it. Certainly, neither the quantity nor the distribution of the pigment would warrant our calling this portion of the growth melanotic.

The stroma consisted of a finely granular, slightly fibrillated material. Blood vessels, as such, were not discoverable, but in certain small areas there existed an arrangement of embryonic-looking tissue, which probably belonged to the vascular system; here and there were channels of various widths enclosing quantities of blood corpuscles, but without definite walls, unless the gradual transition of round to elongated tumor cells, with their long axis parallel to the channel, could be considered as constituting the vessel wall.

It appears from the foregoing that we had to deal with a mixed

growth, the first encapsuled portion being distinctly fibrous in character, and perhaps best designated as a melanotic fibro-sarcoma, whilst the softer, deep-seated growth was evidently a round-celled sarcoma. In both, we are confronted with a wide deviation from the well-known propensities of these growths.

Assuming, as I think we may, that the primary lesion was a pigmented choroidal sarcoma, the date of its recurrence in the orbit after removal of the eye may fairly be placed at the period when the persistent orbital and neuralgic pains returned—that is, within a year or two after the eye was removed—inasmuch as the patient was entirely free from them for a year or two after the first operation, but since they returned, has never enjoyed more than a few days relief at any time.

So long as the growth had not extended beyond the limits of the encapsuled portion, its presence would certainly not have been revealed to the patient or to an unskilled observer, since it had not attained a sufficiently large size to encroach visibly upon the surrounding parts and alter their appearance; and in view of its fibrous character, it may very well have been growing slowly for years. The tendency to slow, or comparatively slow, growth in the more fibrous melanotic tumors is, I believe, generally admitted, but I have not been able to find any case on record *that so strongly emphasizes the principle or law as this one does*. Then, again, the round-celled, deep-seated growth can hardly have originated later than four years ago, when the orbit was found to have been nearly filled up.

The sudden enlargement and inflammatory attack of two years ago may have been due to a hemorrhage into its substance, and the obvious tendency to extravasation discovered by the microscope renders this assumption highly probable; nevertheless, the inflammatory attack might reasonably have been expected to excite or increase the tendency to rapid growth, which round-celled sarcomata are well-known to possess. This, however, clearly did not occur, and in spite of the apparently favorable conditions for rapid development, the case preserved its original torpid character to the end, and it is to be hoped the anticipated recurrence will follow in the same line.

I have been unable to arrive at any satisfactory explanation as to why pain was so conspicuous a symptom throughout the past ten years, for, however easily we may understand the pain which existed for years before enucleation of the diseased eye, there was certainly nothing in the nature, size or position of the orbital recurrence that should have rendered it the source of great or persistent pain; but the freedom from pain since its removal indicates the one as the cause of the other.

## CASES IN PRACTICE.

BY ALEXANDER SHAW, M.D., WATERTOWN, DAK.

CASE I—*Maggots in the Ear*.—J. B., male, aged 41, typesetter, came into my office hurriedly, and looked excited. He informed me in a somewhat hesitating manner that he had maggots in one of his ears, and to prove his assertion, showed me several which he had removed by means of a match. He suffered no actual pain, but a peculiar sensation as if something were moving in his ear, which made him feel nervous. Has had a purulent discharge from the ear for about twenty years. He said that a few days ago a fly got into his ear, and remained there some hours. Taking the ear-mirror and looking into the ear, I found the auditory canal fairly alive with maggots. I at once resorted to syringe and water, and removed forty-five maggots, each about one-eighth of an inch in length. All were alive and moved actively in the water. I again looked into the ear and could see the whole length of the auditory canal, but did not discover any more maggots. I now dried out the canal with cotton, and thinking I had removed all the maggots, sent my patient away, telling him to return the following day for further treatment. He returned in three or four hours and said he thought there were more of those animals in his ear, as he felt the same peculiar sensation he had felt before. While he was talking he put his finger in his ear and brought one away. I again used syringe and water, and removed thirty-four more. I now discovered how they had previously escaped my notice. At the inner end of the auditory canal there was a small piece

of necrosed tissue which had not become wholly detached, and also a narrow rim of the destroyed membrana-tympani; behind these the maggots would crawl, and give a good deal of trouble in getting them away. The following day, with a good deal of difficulty, I succeeded in getting one more away. It would no sooner come into view than it would again disappear. This one proved to be the last. I thus removed eighty in all, the patient himself taking away at least ten or twelve. It is an enormous number of maggots to have in the ear, although they were small. Had they been allowed to remain a few days, they would no doubt have set up more symptoms of a marked character.

CASE II—*Injury to Deltoid Muscle*.—J. H., aged 45, farmer, while out hunting, fell on his right elbow, the forearm being bent. He does not know in what direction from the body the arm was. He feels a little soreness about the insertion of the deltoid muscle. At this point there is a good deal of tenderness on pressure, and when he makes any attempt to raise the arm an acute pain is produced at the same place. The pain produced is so severe that he cannot move the arm from the side at all. The movements of the forearm—flexion, extension, pronation and supination—are all normal. There is no deformity about the shoulder, no fracture, nor dislocation. On taking hold of the arm I can move it in any direction without giving him any pain. When I raise the arm to the horizontal position, and maintain it there, he can, by his own efforts, raise it above his head without causing any pain. It was several weeks before he could succeed in moving the arm from the side, and for several months it remained weak.

I look upon the injury in this case as being in the tendon of the deltoid muscle, at or near its insertion. It illustrates very well the action of the deltoid muscle, which is to raise the arm to the horizontal position, and no further. When the arm is at right angles to the body, other muscles, especially the serratus magnus, are brought into action to raise it above the head, as was well shown in this case.

CASE III—*Poisoning by Oil of Tansy*.—Mrs. A., aged 27, married; has two children. I was hurriedly called to see the patient, as it was said she was dying. In two or three minutes I was before the patient, and found her sitting on the floor supported by one or two women. She was unconscious; there was flushing of the face, frothing at the mouth, and stertorous breathing. The skin was warm and moist, and the pupils normal in size. I was told that she had had spasms, and one of the women present informed me that she had taken, about two hours previously, forty drops of ergot for the purpose of procuring an abortion, as she feared that she was pregnant. She now recovered consciousness while being put to bed, and almost immediately began vomiting. I now ascertained by the odor of the substances vomited that instead of ergot she had taken tansy. The vomiting was encouraged by sulphate of zinc and warm water. She soon got better, but for a day or two the stomach was irritable, there being a little pain and some vomiting. These finally passed off, and she made a perfect recovery. After her recovery, she informed me that she had taken twenty drops of the oil of tansy about two hours before the convulsion came on. The first indication she had of sickness was a dizziness, immediately after which she became unconscious.

---

## QUARTERLY RETROSPECT OF SURGERY.

By FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., Etc.,

Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

*Treatment of Urethral Stricture*.—Dr. Wm. M. Stoker lately read a paper before the Surgical section of the Academy of Medicine of Ireland on the “*Treatment of Urethral Stricture by Internal Urethrotomy*.” (*Dublin Journal of Med. Science*, June, 1885.) After discussing the reasons for abandoning the treatment of stricture by Holt’s method or “divulsion,” he went on to say that if a stricture be tolerably recent, and if time and circumstances will permit, gradual dilatation may be tried, and will for a limited period be successful. Cases are met, however, where frequent catheterization will not be borne, or the circum-

stances of the patient demand speedy relief; in such cases the surgeon need have no hesitation in recommending division of the contracted portion without delay. He would go even further; he would not hesitate to divide any stricture, however recent, provided it were confirmed, and either unsuited to the gradual dilatation or disposed to recontract after it, and that the kidneys were healthy. In cases of old stricture, he would always divide internally, except in cases with old standing perineal fistulæ. In these latter cases, he said, nothing short of an external operation is likely to succeed. If the perineal fistula is recent and solitary, internal urethrotomy should be tried as a primary measure. Dr. Stoker, in performing internal urethrotomy, prefers cutting from before backwards after the method of Maissonneuve, and he stated that he had performed the operation 25 times without a death. In one case only did troublesome hæmorrhage occur. In but one case had there been any return, and some had been operated on ten years ago. Dr. Stoker prefers incising the upper wall of the urethra, because less hæmorrhage follows this incision. If hæmorrhage should occur, then he ties in a large catheter. After the operation, a large catheter should be passed and immediately withdrawn; then every other day, for a month, a No. 12 to 14 should be passed, and after that once a week for the rest of the patient's life. The following are his conclusions:

1. Internal urethrotomy is superior to any form of dilatation.
2. Maissonneuve's method is much better than that of Civiale and his followers.
3. Certain details should be followed out, as (*a*) completeness of division, (*b*) disuse of anæsthetics, (*c*) incision of upper wall of urethra, and (*d*) non-retention of catheter in the urethra subsequent to operation.

To this latter procedure Dr. Stoker attributes the freedom of his cases from inflammation and other troubles.

In a paper by Mr. Reginald Harrison in the *British Medical Journal* of July 18th, 1885, on the "*Treatment of Urethral Stricture by combining Internal and External Urethrotomy,*" he says he differs materially from many surgeons of large experience as to the advisability of the operation of internal

urethrotomy in the majority of cases. He thinks that a person with stricture had much better employ dilatation in some form or other, so long as he can keep himself comfortable and the size of the urethra is not progressively diminishing. Internal urethrotomy, Mr. Harrison holds, is extremely liable to be followed by a form of fever which is exceptional, unexplainable, and occasionally fatal. It is not the ordinary wound fever of operations; it is generally ushered in with a rigor, and, in its course, presents every degree of mildness and severity. It is occasionally attended with suppression of urine, and it sometimes proves fatal in cases which seem well adapted to operation, and after death no satisfactory explanation as to its cause or pathology can be offered. He holds, also, that internal urethrotomy does not furnish better permanent results than other methods of treatment, besides, after the most successful performance of the operation, the patient is obliged to pass an instrument at intervals for the remainder of his life, which indicates that only a partial good at the best is to be hoped for from the operation. On theoretical grounds, Mr. Harrison thinks the operation has much to recommend it, and on carefully considering the whole subject, it seemed that, if it were possible to assimilate the performance of internal urethrotomy with some other operations on the urinary apparatus, where there was absence of any special form of fever or septic intoxication following them, and where the wounds inflicted did not deal with scar tissue, which subsequently manifested an inordinate disposition to contract, the more prominent objections connected with internal urethrotomy might be mitigated, if not entirely removed. He attributes the rigors, fever and other symptoms following urethrotomy to the passage of urine over the cut surface, and quotes Prof. Berkeley Hill, who says that in the cases of internal urethrotomy performed by him, where the catheter was afterwards left in to lead off the urine there were no rigors or fever, but in those cases where a catheter did not lead off the urine, the temperature remained normal for as many hours as the patient refrained from micturition. He also mentions that Prof. Bouchard has drawn attention to the poisonous effects of normal urine when injected into the blood, even in small quantities.

Mr. Harrison, in certain cases which would not yield to dilatation, has performed a double operation—first internal urethrotomy and afterwards a perineal section, and introduction through this into the bladder of a drainage tube. The urethra is opened from outside, of course behind the stricture, and in the membranous portion. Thus the urine is voided through the tube, and the wound made in the stricture by the urethrotome protected against urine passing over it. He has operated in this way twelve times, and after this double operation there has never been a rigor or any fever. The urethra has been placed at rest, the process of repair has been facilitated, and the urethra has healed up, or, to use his own words, “a cicatricial splice has been formed and completed without contact with urine or other possible source of irritation.”

The perineal operation is performed as follows: Patient being placed in the lithotomy position, and a grooved staff introduced, the membranous urethra is punctured with a long, straight finger knife one inch in front of the anus, the back of the knife being towards the rectum, the incision is slightly enlarged forwards so as to permit the introduction of the index finger. If the staff be found exposed at the bottom of the wound, all is well and good; but if not, along the finger, reintroduced to the bottom of the wound, is passed a blunt, though pointed knife, with which the few remaining fibres that remain between the tip of the finger and the groove are cut away. When the groove of the staff is felt, Wheelhouse's small probe-pointed gorget is slid along it, the staff is withdrawn, and the drainage-tube passed along the concavity of the gorget into its position. The drainage tubes are of gum-elastic, four or five inches in length, and somewhat thinner than an ordinary index finger. The tube should be just within the bladder and no more. They are secured by an eye on each side, through which a tape can be passed.

Mr. Harrison believes that he, by this double operation, not only avoids urinary fever, but that the cicatricial slice formed in the urethral stricture has not so much tendency to contract as the scar tissue would when the surface is being continually irritated and exposed to septic influences. To facilitate this

he washes out the urethra with an antiseptic solution, and occasionally introduces a small drainage-tube into the meatus and out of perineal wound, and keeps this aseptic by washing out with some antiseptic injection. He says this operation is not applicable to penile strictures or those behind the scrotum, and is suitable only to those cases of bulbous stricture which do not yield to dilatation.

The proper method of treating organic strictures of the urethra has been for years a much-vexed question. Each writer recommends a certain form of treatment as the only sure way of getting good results. Some advocate gradual dilatation; others internal urethrotomy not only in cases of old standing relapsing strictures, but in *every* case of stricture, even those which are only detected by means of a No. 25–30 sound. Some surgeons, even yet, in bad cases invariably perform external urethrotomy, and extol the wonderful benefits of this operation; a few still recommend divulsion, and some the combined operation of urethrotomy and divulsion. Again, internal urethrotomy itself is performed in various ways, and each way has its ardent supporters, who condemn every other method. Some cut from behind forwards, others from before backwards; some incise the upper wall of the urethra, and others the lower; some make a number of cuts, others only one; some leave the catheter in after the operation, whilst others attribute their success to leaving it out. The instruments are of endless variety, vying even with those used by the gynæcologist for treating the os uteri. One man invents an instrument, another modifies it, and this is again modified, and so on *ad infinitum*. The probability is that the good result obtained depends more upon the operator than the method of operating and the kind of instrument used. The old treatment of stricture by cauterization with the solid stick of nitrate of silver is still advocated by some surgeons.

Sir Henry Thompson, who, perhaps, has had more experience than any living surgeon in the treatment of stricture, said in his lectures, delivered last year before the Royal College of Surgeons, that at first it was only in the worst cases that he resorted to internal urethrotomy, but that now he has been practising it

with continually greater freedom. He had performed (at the time of the lectures) internal urethrotomy on between three and four hundred patients, with a mortality of less than 3 per cent. He only performs the operation in those cases where the stricture shows a tendency to recontract, or which are intolerant of bougies. In performing the operation, Thompson uses Civiale's method, cutting from behind forwards and in the floor of the urethra. Before performing this operation, it is necessary that the urethra should be dilated to the size of a No. 5 bougie; if the stricture be tight, then a small bougie is introduced and tied in for two to four days, and when it is withdrawn, the stricture is dilated sufficiently for the passage of the urethrotome. Immediately after division a large sound is passed, and if there is any difficulty, the urethra is again incised. A gum-elastic catheter is now tied in for at least 24 hours. In cases where the stricture returns after urethrotomy, Sir Henry Thompson repeats the operation. This he finds necessary in the majority of cases. In a very few only is the relief permanent.

Last year, at the meeting of the British Medical Association (*Brit. Med. Journal*, 1884), Mr. Walter Coulson read a paper on *Internal Urethrotomy*. After describing the various methods practised by different surgeons, he stated his preference for the operation, cutting the roof of the urethra from before backwards, and the instrument recommended is Teevan's modification of Maissoneuve's. After the cutting is over, a full-sized silver catheter is introduced, the bladder emptied, and the instrument immediately withdrawn. Then the patient must remain in bed, with hot bottles to the feet, and take three grains of quinine in half an ounce of brandy. If no rigors occur, the patient has a hot bath at night, and 48 hours after a large-sized bougie is introduced and the patient allowed to get up; afterwards a bougie is passed every three or four days for a fortnight, when the patient is instructed to pass one for himself once every week. As to the results—out of 206 operations performed at St. Peter's Hospital, 10 terminated fatally. In many cases no anæsthetic is used, and the cure is permanent and radical in the cases that recover.

In my experience, the cases that cannot be treated success-

fully by gradual dilatation are few indeed, and I have rarely, except in penile strictures, which do not dilate easily, found it necessary to perform either external or internal urethrotomy. If the same treatment recommended after internal urethrotomy (that is, regular passage of bougies or sounds) be carried out faithfully, I think quite as few strictures will be found to recontract after *gradual* dilatation as after internal urethrotomy. Of course dilatation takes time, which cannot always be afforded; and tests the patience of both the surgeon and the sufferer, but it is infinitely safer than any other method of treatment. It seems to me that a mortality of 5 per cent. is too large a one to undertake the operation hastily and without due consideration. Even an experienced operator like Thompson has a mortality of 3 per cent. Certainly in some cases, such as old indurated multiple strictures, resilient strictures, and where the passage of a bougie is followed by rigors and great elevations of temperature, internal urethrotomy is indicated, and in others, where there is much induration and many perineal fistulæ, external urethrotomy is advisable, but these cases are not very common, and many of these can be successfully treated by gradual dilatation.

The fever following catheterization is often controlled by full doses of quinine (10 grs.) or 10 grs. of Dover's powder and confinement to bed for a day. I have only seen one death following dilatation, and that was recently in an old case of stricture with advanced disease of the kidneys. That the passage of urine over the cut or torn surface of the urethra always explains the occurrence of urethral fever I can hardly believe; if so, why is it that in some cases of stricture a catheter cannot be passed without the occurrence of rigor and fever, whereas if a large dose of quinine or 10 grains of Dover's powder be given in the same cases these untoward symptoms do not appear. I have seen several such cases. The fact that opinion is divided as to tying in a catheter after the operation shows that the cause of urethral fever is not yet understood. Mr. Harrison's double operation no doubt offers certain advantages, but I fear it will never be more popular than preliminary tracheotomies in operations on the mouth. It will be hard to persuade surgeons that a double operation does not increase the risk.

In America especially has the treatment of internal urethrotomy been carried to excess ; not only is it performed for every case of real and supposed stricture, but even for gleet. Only the successes are published ; the failures and fatalities are little heard of. The reason gradual dilatation is not popular is (first) that it is tedious, and that the immediate results are not so brilliant as urethrotomy, and (secondly) that the fashion has changed. I am sure, if a surgeon had to treat himself for an ordinary stricture, he would much prefer gradual dilatation to the cutting operation.

Dr. Robson (*Brit. Med. Journal*, March 7th, 1885) reports a case of traumatic stricture treated successfully by excision. He recommends this operation in all forms of relapsing strictures and those which do not readily yield to treatment, especially if situated anterior to a point half an inch in front of the membranous urethra. After the excision, a catheter is tied in, and the cut surfaces of the urethra sewed over it. Six months after the operation, a No. 13 sound passed easily.

Mr. Swinford Edwards, F.R.C.S., in the *Brit. Med. Jour.* of July 11th, 1885, publishes a lecture on "*Bougies, their Use and Abuse*," in which, after describing the various kinds of bougies and the method of using them, says he is no friend to the treatment of stricture by continuous dilatation, for he believes it to be more fraught with danger to the patient than internal urethrotomy. He, however, gives no reasons for this statement. He also says that he does not hold with the practice of tying in a catheter after the operation of internal urethrotomy, as he is of opinion that the irritating presence of an instrument in the urethra will almost certainly set up inflammation of the urethra and bladder, and that we may congratulate ourselves if our patient escape urethral fever leading to suppression of urine and death. Perineal abscess, extravasation of urine, and orchitis, are other local complications. Any, or all of these, may succeed the passage of a bougie, "but," says the author, "they are certainly more likely to occur in treatment of stricture by continuous dilatation."

I confess that I am somewhat surprised at these opinions of

Mr. Edwards, which are at variance with the experience of most surgeons. Sweeping statements such as these, unsupported by facts, do harm, and only tend to show the marked bias of the author in the direction of his own private method of treatment by urethrotomy.

*Operative Treatment of Enlarged Prostate.*—Prof. E. Bottini, by an operation entirely original, has succeeded in permanently relieving ischuria due to prostatic enlargement. The operation was performed in July last, and the permanence of the results gives promise of a noteworthy addition to the surgical treatment of prostatic disease, which heretofore has been considered as almost entirely tentative. The patient was a man aged 68, and for the last five years had difficulty of micturition. This increasing, and the patient losing strength, Dr. Bottini proposed cauterization. Previous to the operation, the bladder was treated with solutions of boracic acid and sulpho-carbolate of zinc, and the attempt was made to strengthen the contractility of the bladder by cold injections. After a few weeks, the conditions becoming more favorable, the patient was chloroformed and the galvano-cautery introduced into the urethra with the cauterizing blade against the enlarged prostate. The instrument was so constructed that all parts, save that by which heating was necessary, were kept cool by a current of ice water. Cauterization of the prostate was continued 45 seconds, which then being deemed sufficient from the inclination of the instrument, the current was broken. On the withdrawal of the instrument, all parts were found to be cold. The patient was put to bed and a catheter left in the urethra. Four days after the operation the patient was without fever; the bladder was washed twice a day with a 2 per cent. solution of sulpho-carbolate of zinc. On the seventh day, small portions of escharotic tissue began to escape with the urine. The first spontaneous discharge of urine occurred about three weeks after the operation, and in three months urination was entirely natural. Eight months after the operation improvement still continued, and the general health of the patient was excellent.—(*Gazetta degli Ospitali*, Feb., 1885, quoted in *Amer. Journal of the Med. Sciences*, July, '85.)

This operation was fully described and the instruments figured by Dr. Bottini in 1877 in Langenbeck's *Archiv f. Klin. Chir.*, Bd. XXI, Hft. 1, and a condensed translation of the article was published in this JOURNAL in August, 1877 (Vol. VI, p. 83.)

Mercier's operation of removing a portion of the obstructing prostate is being practised now by some surgeons. Dr. Gouley of New York has an instrument with which he punches out a piece of the gland. Mr. S. Edwards (*Lancet*, July 11th, '85) reports a case in which he successfully performed prostatectomy with Gouley's instrument, to the great relief of the patient. There was little bleeding and no bad symptoms afterwards, the patient leaving hospital in a week.

Mr. Harrison's operation, which has been highly spoken of, is performed by opening the membranous portion of the urethra and removing the obstruction partly with a probe-pointed knife and partly by divulsion with the fingers. A large tube is then introduced into the bladder, and through this a smaller one to carry the urine. A stop-cock arrangement has been also used, to enable the patient to go about.

At the meeting of the American Medical Association, held in New Orleans in April last, Dr. J. W. S. Gouley of New York read a paper on "*Some points in the Surgery of the Hypertrophied Prostate*" (*Medical News*, May 2nd, '85). After describing the symptoms and diagnosis of this disease, he said the surgical treatment was divided into two parts—1st, Mechanical means of relief; and 2nd, The removal of the organ by surgical means. All hard catheters should be discarded, except in cases of false routes. A soft catheter should have as small and as smooth an eye as possible—never two eyes. Small catheters are usually preferred, but too small an instrument should never be used. Where false passages exist, a large catheter should be employed, and where this fails, the invaginated catheter of Mercier is usually successful. . . . . Evacuatory catheterization should be commenced early in the history of each case, but in old cases, where the bladder has become distended, it is of the greatest importance that all the urine be not removed at one time. The catheter should be used

as often as from twice to five or six times daily. If the catheter be too freely used, many of the alarming symptoms are relieved and patient seems much better than before, but at the end of a few days the patient begins to show symptoms of disease of the kidneys, which proves fatal in a month or six weeks. When there is intolerance of the catheter, he advocated the withdrawal of a small part of the residual urine at intervals of once every few days, until tolerance was established. He laid great stress on the injection of medicated fluids into the bladder in a quantity to correspond to the amount of urine removed. A solution of borax was most employed, but various other agents might be used, as when the urine was strongly alkaline, an acid might be added; when large accumulations of mucus and pus were present, alkalies were indicated; and when phosphates were deposited, weak solutions of acetate of potash were recommended. The use of carbolic acid he did not endorse, but considered the nitrate of silver, in properly diluted solution, one of the most valuable agents we possess. Morphia, hyoscyamus or cocaine may be added in cases of great vesical irritability. In certain cases, especially when the central lobe was enlarged, he advocated removal of the obstructing portion.

In the discussion which followed, Dr. Gouley claimed priority for the operation of excision of the prostate.

*Massage of the Prostate for Retention.*—Dr. Le Rütter, a Dutch surgeon, has found means to subject the prostate to a kind of massage, and in this way has completely cured two patients of the ages of "over 50" and 70 respectively. The method employed is to pass the forefinger up the rectum, and then move the prostate to the right, left, and in a vertical direction three times each way, rubbing it firmly afterwards. This proceeding is, as may be supposed, rather disagreeable to the patient (to say nothing of the operator's sensations), and it cannot be borne for a long time. In one of the cases 20 massages, and in the other 15, were required to effect complete restoration to pass urine freely. In both a small amount of bleeding took place from the urethra, caused by the manipulations of the prostate, for which liquor ferri sesqui-chloridi was given with satisfactory result.—(*Brit. Med. Journal*, Aug. 1st, 1885.)

*Compression in Acute Orchitis, both simple and complicated.*

—This is effected by making gradual traction on the inflamed testicle, thereby separating it, as much as possible, from the external abdominal ring, towards which the cremaster has a tendency to pull it. Having then isolated the organ, several turns of bandage are made around it above, preventing its reascent. From this *point d'appui*, the whole testicle is covered by oblique circles of the compressing bandages, which is afterwards covered by a starched spica-bandage. Mr. Thiry, of the Hôpital St. Pierre, has long been in the habit of treating cases by this means. The author asserts that he has not seen this method fail in a single instance, however acute the inflammation. The effect of compression is at once to give relief to pain. Several cases are recorded in which the cure was complete, on an average, in eight days. The application may have to be repeated daily, according to the rate of diminution of the swelling. Three applications, as a rule, were sufficient.—(*La Presse Médicale Belge*; quoted in *Annals of Surgery*, July 1885.)

This modification of an old method of treatment is not likely to be practised extensively. It is difficult of application, requires time, and, besides, offers no advantages over the ordinary methods, such as applications of ice, hot poultices, or scarification. In cases where there is much pain, I have found no treatment so beneficial as making incisions into the scrotum and applying a hot poultice. Puncture, when there is much distension of the tunica albuginea, is often marvellously effective, but in private practice it is difficult to get the patient to submit to it.

*Radical Cure of Varicocele.*—In the *Lancet*, April, 1885, Mr. Henry Lee describes the operation which he has been in the habit of performing for the radical cure of varicocele. The patient is placed under ether, and on the left side of the bed. A portion of the skin of the scrotum is then pulled up and removed by scissors or a knife, the largest diameter of the wound being transverse. The enlarged veins are easily distinguished from the vas deferens, and any large artery must be separated before the operation is continued. A harelip needle is then introduced through the wound under some of the veins, and

another needle passed half an inch distance under the same veins in the same way, and a figure of 8 ligature is put round the needles and over the veins. The veins between the needles are then divided, and a cautery applied to their divided ends and allowed to remain in contact with them for a quarter or half a minute. The tissues adhere firmly to the cautery, if not too hot, and are gently separated by the handle of a scalpel. The needles placed under the veins are now removed, and the edges of the wound brought together by short harelip pins or by a continuous carbolized catgut suture. The wound generally heals in great part by first intention, and the patient can walk about in a week. In some cases where the scrotum is not relaxed, the subcutaneous division of veins answers very well without removal of any skin.—(*London Medical Record*, June 1885.)

*Worsted Truss for Infantile Inguinal Hernia.*—Mr. Edward Lund refers, in the *Brit. Med. Journal* for June, 1885, to the worsted truss described by Mr. Coates in 1849, and strongly advises its use. A skein of Berlin wool is looped across the abdomen; one end of the loop is placed directly over the outer abdominal ring, the hernia being reduced previously. The folded worsted is passed horizontally across the abdomen, above the line of the crest of the os pubis, to the opposite side, round the hip, behind the pelvis, and over the hip of the side of the hernia. The folded end is then passed through the loop of the skein, and will here form a knot or bulged portion, which must be carefully adjusted so as to lie against the hernial opening, and, being carried down the upper part of the thigh, between it and the scrotum (if a male), it is brought round the external side of the thigh near to the top of the great trochanter, and there tied or fixed with a safety-pin to the band of worsted already round the pelvis. There is an advantage in the fact that the child can be bathed with the truss on, and a fresh one then be applied, the first being dried and cleaned for future use.—(*London Medical Record*, July, 1885.)

*Treatment by Section of Hydrocele by the Antiseptic Method.*—In discussing the treatment of hydrocele by the above method, Mr. Edward Bellamy says (*Lancet*, July 4th, 1885): "The

few remarks I make are based on a considerable number of cases I have treated both in hospital and in private practice, in the early and later stages of hydrocele, by which latter I mean those which have been repeatedly tapped and in most instances injected. It is hardly necessary to take up space by instancing individual cases. It is certainly time that the old-fashioned method and the supposed radical cure by continuous injection was done away with, as painful, dilatory, and generally useless. I claim no originality whatever in this treatment. I desire to call the attention of practitioners to the fact that they should invariably adopt the method of free incision with strict antiseptic precautions, and I cannot understand why it is not more universally carried out. Every surgeon knows of the method, but, as far as I can see, contents himself with adhering to the usual proceedings. There is no danger in it. An anæsthetic may be given if necessary. The healing is rapid; the cure almost certain, if not absolutely so. The operation is as follows: The diagnosis, of course, being established, the scrotum should be shaved, and (if the surgeon thinks necessary) the spray used; the tumor is firmly grasped so as to render the parts as tense as possible. A clean sweep through all the scrotal tissues is then made with a bistoury from the cord to the base, and the fluid escapes. Every bleeding vessel, however small, must be twisted or tied most scrupulously, and the interior of the sac carefully examined for any vessel which may have been wounded or given away. The cavity should then be stuffed, not too tensely, with either lint soaked in 1 to 40 carbolic oil or gauze, and the upper part of the edges of the wound stitched together, including all tissues. A small tag of the contents being left out of the most dependent part in the contingency of drainage, a pad of salicylic wool is placed over all, and the scrotum supported by a cushion between the thighs. In a couple of hours the parts may be dressed and the contents of the sac withdrawn. As a rule, considerable contraction of the walls of the sac will have set in, but it is advisable still to introduce the antiseptic material so long as any appreciable cavity exists, and this is generally for about a week in very favorable cases, when it will be found impossible

to pass anything into it, and merely the lips of the original wound are left to close. Tubal drainage is, I venture to think, unnecessary. I have not yet met with any untoward constitutional symptoms by adopting this method, which is equally applicable to encysted hydrocele of the cord.”

*Hydrocele cured by Elastic Pressure.*—In the *Meditz Obozreine*, No. 21, 1884, p. 808, Dr. P. G. Rosanoff of Zvenigorod records a case of chronic hydrocele in which complete cure ensued after wearing a well-fitted elastic bag for about six weeks. An examination of the patient 15 months later showed that he was still entirely free from the former disease.—(*Lond. Med. Record*, Feb. 1885.)

*Treatment of Gonorrhœa by a New Drug.*—The new drug here referred to (*Lancet*, Feb. 28th, 1885) is *Jacaranda lancifoliata*—a plant indigenous in Colombia, South America, and used by the natives for venereal diseases. This drug in Mr. Wright's hands has proved most efficacious in diminishing pain and stopping discharge in acute cases; while it has been successful in several cases of gleet which had resisted previous treatment. A liquid extract is made from the leaf, and may be given in doses of 20 to 30 minims three or four times daily.—(*London Med. Record*, June, '85.)

*Hebra's Treatment of Soft Chancre by Salicylic Acid.*—After washing the penis with lukewarm water and soap, and drying it well, the powdered acid is applied to the sore and its edges, and maintained in place by pledgets of cotton wool. The application is renewed after 24 hours, and on the third day simple ointment is substituted for the acid. Twelve hours later this eschar disappears, and after about three days the sore is healed.—(*Lond. Med. Record*, June, 1885.)

## Correspondence.

## LETTER FROM BERLIN.

BERLIN, July 7, 1885.

The appointment to fill the vacancy created by the death of Prof. Frerichs has, after a good deal of "red tapeism," finally been effected. As intimated in a former letter, Prof. Leyden becomes the direct successor of the late Prof. Frerichs. He will consequently enjoy the singular fortune of being the immediate successor of Germany's two greatest clinicians—Traube and Frerichs. Prof. Gerhardt of Wurzburg has received and accepted the call to the chair vacated by the above appointment. But, hereafter, the two clinics will rank equally; instead of being called "No. 1" and "No. 2," as heretofore, they will be known respectively as the "Gerhardtsche" and the "Leydensche" clinics, each having the same number of beds, assistants, etc.

The newest star of the Berlin University is described as a short, thick-set man, running into the fifties, with hair beginning to turn gray. He studied medicine at Heidelberg and Wurzburg, and began his academical career as clinical assistant to Bamberger and Rinecker at the latter University. In the beginning of the year 1870 he was appointed ordinary professor to the chair of internal medicine at Jena. Here the goddess Fortuna showered down her German blessings upon his head in putting under his care two German princes during an illness that ended in complete recovery. In 1874, when Prof. Bamberger of Wurzburg received the call to Vienna, Prof. Gerhardt was the only candidate for the vacancy, an honor that has its counterpart with us in the political world only—an election by acclamation. At this University he received his present call, and does not come to Berlin until the opening of the winter semester. As an author he has acquired considerable fame, at least in Germany, by his works on "Diseases of Children" and "Auscultation and Percussion."

Prof. Senator conducted the clinics *pro tem.* during the summer semester, and as he filled the post so ably, it was thought by

many that he would be permanently appointed. It is rumored about—I don't know with what truth—that the present bigotry, learnedly called “anti-Semitism,” prevailing in Germany has been the indirect cause of his not being appointed. Professor Senator won great popularity during his short course as lecturer. In spite of the uncomfortable hour, between 11 and 12, at which time the sun unmercifully poured its rays through the unscreened windows of the auditorium—in spite of the heat and ill-ventilation, the auditorium was crowded every day he lectured. Many had to stand,—your correspondent feelingly refers to these, as he formed one of the unfortunates. Last week the students gave Prof. Senator “a fest-commers.”\* On this occasion all the speakers referred to the almost unprecedented incident of a professor winning such popularity in so short a time; and also to the unprecedented course (Germans speak bluntly) of the Faculty in appointing one from another University when there existed already one in their midst who, in every way, could so well fill the post. When one takes into consideration whom he had to succeed, and that without any time for preparation, Prof. Senator's success really becomes remarkable.

The saying of the wise king, which has been repeated by sundry philosophers and wits since his time, “that there is nothing new under the sun,” met with an apparent contradiction the other day, at one of the clinics, in the form of that “*rara avis*”—a really unique case. The case in question was symmetrical external ophthalmoplegia, with ptosis, the superior oblique only remaining unaffected. The patient has to carry his head thrown back, and to one side, in order to see anything. The singular and interesting features of the case has still to be mentioned. It was congenital and hereditary. The patient's mother suffered from the same affection, having acquired it in middle life, and his only child, a little girl of 18 months, came into the world with precisely the same condition. The father and daughter were presented at both Prof. Hirschberg's and Mendel's clinics. Both of these professors said they searched medical literature in vain for a similar case.

---

\* A banquet consisting of indifferent beer in unlimited quantities, bad music and worse singing.

The pendulum of "meddlesome midwifery," after having reached its maximum limit when every accoucheur felt it his imperative duty to remove a retained placenta two hours after delivery, forcibly by the hand introduced into the uterus or by the curette, is beginning to swing in the opposite direction. Here in Berlin, Schröder and Gusserow teach that there is no harm in leaving the placenta in utero for even two days should no alarming hæmorrhage occur. They would forcibly remove the placenta only on the appearance of the latter symptom; otherwise they think it is much safer to leave it intact. Great danger, they say, resides in forcible removal, for, as a rule, a portion of the placenta remains attached to the wall of the uterus. This is almost certain to undergo putrid decomposition, and very likely to give rise to septic fever. But the intact placenta may remain in utero two days or longer without undergoing any decomposition. In most cases of retained placenta, the unaided uterus will have cast it out before that period of time elapses. This teaching carries the greater weight with it, as it comes from men who are strong adherents of strict antisepticism.

Your readers will doubtless be pleased to learn that Dr. Ruttan, Demonstrator of Chemistry in McGill University, who has been here in the chemical laboratory during the summer, has had the good fortune to discover a new chemical body, a hydro-carbon, which, with its derivatives, complete an important group in the aniline series. True chemist to the core, his ecstasy as a discoverer is marred by the fact that the discovery is likely to be of practical benefit. A full account of the compound will, I believe, shortly appear in the "Bericht für Deutsche Chemie Gesellschaft."

H. N. V.

## Hospital Reports.

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

## CASES OF LEAD-POISONING.

UNDER DR. MOLSON.

CASE I—“*Cerebral Plumbism*” — *Delirium* — *Paralysis* —  
*Coma*—*Death*.

E. G., aged 24, single, employé in white lead factory, was admitted October 21, 1884, suffering from lead colic—intense abdominal pain, diarrhoea, stools mucous and green, severe headache, and general weak condition. Family history negative as regards nervous diseases. Has always enjoyed good health, with the exception of an indefinite history, obtained from the patient, concerning past attack of temporary insanity, not corroborated by friends. Pursued study of medicine for two years in Dublin University; was very intemperate. The patient arrived in this country nine months previous to admittance; for six months out of the nine had worked in white lead factory, during which time had had several slight and severe attacks of colic, obstipation, with clay-colored stools and marked fœtor. Gradually became weak, and mental condition subsequently becoming affected, incapacitated patient for work. For the last three years was in the habit of using morphine in large doses to overcome the horrors of dissipation.

*On admission.*—Very anæmic and sallow; emaciation marked; muscles soft and flabby; conformation good; anxious, troubled expression, pupils dilated, very much excited, and difficult to control as regards keeping in bed. Intense abdominal griping pain, severe in umbilical region, but diffused over all areas; pain somewhat relieved by pressure. Tongue dry and brown; anorexia. Nausea; no vomiting. Bowels relaxed; stools greenish and very offensive. No cough or other pulmonary symptoms. Absence of any definite paralysis or paresis as regards extensors of forearm or leg; all other muscles in normal condition. Statements not to be relied upon; frequent hallucinations and delirium

at night; persists in leaving bed and wandering about wards. Pulse 110, weak, rapid and compressible; respirations 26; temperature 100°.

*Examination.*—Gums show a distinct, pathognomonic, intense dark lead line just beyond margin of gums; teeth covered with tartar. Lungs and heart negative, with exception of pulmonary accentuation of second sound. Urine: specific gravity 1020, high color, acid; no albumen or lead detected by most approved tests.

*Treatment.*—Potass. Iodide grs. xv every six hours.

*Oct. 23, 24 and 25.*—Remained in about same condition. To control delirium at night, Chloral Hyd. 5ss was administered. *28th.*—Very restless; delirium constant, low muttering in character, with frequent hallucinations. Chloral discontinued; find patient to rest much better. Evening temperature 101°; morning, 99°. Pulse weak, 116. Tongue dry and brown. Colicky pains less. Otherwise, condition same as when admitted.

From Oct. 30 to Nov. 20 nothing of special note occurred, with exception of patient becoming gradually weaker, and to-day can scarcely elevate hand to head; arm finally dropped over edge of bed, patient unable to elevate. Marked tremor when attempting to perform any definite movement. No wrist-drop or other localized paralysis. Great loss of power in legs, especially right. Lead line on gums as before. Pulse 120, very compressible. Temperature ranges 101°—98°. Mental condition, restless, insomnia, delirium, accompanied by hallucinations and low muttering, are the prominent features; patient continually tossing from side to side, and rolling head about in all directions.

*Nov. 25.*—Very restless at night; somewhat aphasic; speech thick and faltering; semi-comatose; arms and legs becoming weaker; other conditions same as last note. *27th*—Wrist-drop gradually becoming marked in hands the last few days, and now seen to perfection; absence of similar conditions in feet. Semi-comatose.

*Dec. 3.*—Gradually losing ground; condition one of extreme prostration, with coma. Pulse 140, compressible, and exceed-

ingly weak; temperature  $101\frac{1}{2}^{\circ}$ . Died this morning at eight o'clock from exhaustion.

*Post-mortem examination.*—Lead line on gums confirmed by microscopical and chemical examination. No organic lesion in brain or cord. Granular degeneration of flexors and extensors of forearm. Liver, spleen and kidneys soft, slightly enlarged, and friable; no change otherwise. No deposit of lead found in any of the organs.

#### UNDER DR. ROSS.

##### CASE II—*Wrist-drop—Improvement.*

D. C., aged 25, seamstress, single, was admitted January 9, 1885, complaining of complete loss of power in her arms and hands. Emaciation of same and general weakness. Has always been very strong and healthy up till three years ago. At that time suffered from an attack like the present—weak, numb and emaciated condition of arms and hands; came on gradually, and lasted for two years. Loss of power not complete; able to perform light work, but could not accomplish fine movements. Lower extremities normal. Recovery gradual. Since then, and up to two months ago, enjoyed fair health, and had almost complete return of power to upper extremities. Absence of all abdominal symptoms except constipation. No history of rheumatism, syphilis or traumatism.

*On admission.*—Anæmic, sallow, general emaciation slight, expression dull and stupid, pupils dilated, skin dry and rough, tongue heavily coated, breath foetid, obstipation and deficient appetite; no abdominal pains or other symptoms of colica pictonum. Muscles of hands and arms soft and emaciated, and skin hangs loosely. Thenar and interossei muscles very much wasted; can with great difficulty raise hands to head or opposite shoulder: sensation good. Dynamometer shows 5 lbs. for each hand. Marked wrist-drop, simulating the paws of a kangaroo. Considerable loss of power in lower extremities. Gait weak, unsteady, extensors being the muscles principally affected; sensation normal. Reflexes present, very weak and difficult to produce. No ankle clonus. Perfect control over functions of

bladder and rectum. No fibrillar contractions or tremors; condition of central nervous system normal. Examination of heart and lungs results in negative facts. Urine: specific gravity 1021, acid, color light; no albumen or lead detected. Characteristic extensive lead line following margin on both upper and lower gums.

*Treatment.*—Ferri et Strych. Cit. grs. iii t.i.d.; also put hands and arms up in splints.

*Jan. 16.*—Lead line same as last note. Dynamometer shows left 6 lbs; right 5 lbs. Bowels regular; had to use purgatives freely. No headache. Pulse 80; temperature at all times normal.

*March 16.*—Since last note, motor power in arms and hands has been gradually increasing, and regained somewhat the loss in substance. Wrist-drop remains, but very slight. Dynamometer 7 lbs. each. Considerable return of power in legs; can walk fairly well. General condition good comparatively speaking. Exit to-day. Have been unable to follow case outside. In this case it was found impossible, after careful investigation, to determine the source of the lead contamination.

### CASE III.—*Severe Colic—Slight Wrist-drop—Improvement.*

O. B., female, aged 29, servant, single, sought admission into the hospital on the 13th of February, 1885, suffering from general weakness, pain all over body, but chiefly situated over areas of abdomen. She gave a history of general delicate health for the past four years; previously quite well and strong. At that time confined; post-partum hæmorrhage followed, which left patient very anæmic and weak.

*Present condition.*—Muddy, sallow complexion; very anæmic; pupils dilated, dull, heavy expression; tongue coated; breath foetid; appetite diminished; obstipation; constant headache. No marked emaciation of body in general. Muscles of arms soft and flabby. Motor power good; sensation normal. Wrist-drop to slight extent. Condition of lower extremities weak. No paralysis of extensor muscles; sensation normal; reflexes present, equal and normal. Abdomen somewhat scaphoid, hard,

tender over epigastric region. Some griping, colicky pains, relieved partially by pressure. Gums pale, characteristic well-marked lead line. Urine: specific gravity 1012, acid, color high; deposit of mucus and lithates; no albumen or lead. Heart and lungs negative.

*Treatment.*—Potass. Iodide gr. x ter die; purgatives; liniment, Chlorof. with Opium applied to extremities.

*Feb. 20.*—Wrist-drop well marked; abdominal colic and other symptoms same as when admitted.

*March 21.*—Could not impress upon patient the necessity of remaining in hospital. Left this morning, condition being somewhat similar as when admitted. Wrist-drop present to slight extent. Can walk well. Bowels regular, and abdominal pain only occurring at long intervals. Has metallic taste in mouth. Gums in same condition. Continued taking iodide for two weeks, under observation, after exit, but subsequently lost sight of.

#### CASE IV.—*Epilepsy—Semi-coma—Paresis—Cure.*

H. M., aged 54, single, employé in black-lead works, was brought to the hospital on 24th of May, 1885, in a state of semi-unconsciousness, unable to walk without assistance. Impossible to obtain any history from patient, but found condition to be as follows: Anæmic; sallow subicteroid hue; pupils equal, very sluggish; restless, insomnia, and persists in leaving bed; wandering delirium; hyperæsthetic condition of legs, but especially abdomen; cries out lustily when pressed upon; belly flaccid, absence of any tumor or other abnormal condition; no vomiting or purging; tongue coated (breath offensive), edges irregular and lacerated, with recent and old scars caused by teeth during convulsive seizures. Appetite deficient and bowels constipated. Has bruise beneath right eye. Nothing simulating a fit since admitted. Extremities somewhat emaciated; muscles soft and flabby.

*Examination.*—Sternum prominent; chest, grey-hound in shape (rachitic); ribs flattened laterally, intercostal spaces small; expansion deficient; percussion and other physical signs normal; heart negative; pulse 100; respirations normal; tem-

perature  $98\frac{1}{2}^{\circ}$ ; liver and spleen, area of dulness normal; urine, specific gravity 1020, color very light, acid, no albumen, deposit of mucus. Ordered Potass. Bromide grs. x every two hours.

*May 25.*—Patient much improved; slept well: not rational yet; remains quiet; delirium disappeared; pulse 80; temperature  $98^{\circ}$ ; hyperæsthetic condition absent; tenderness over abdomen, especially epigastric area. Interviewed friends and found that patient had had several fits of an epileptic character on Friday, May 22, '85, but never had anything of a similar nature before. Had a paroxysm shortly before admittance to hospital. Family history found to be negative as regards nervous diseases. Has considerable difficulty in articulation; thick and unsteady speech. Complains of inability to move tongue, as before attack. Right arm, motor power deficient; sensation normal. Left arm and lower extremities examined and found to be in good condition.

*May 26, 27.*—Gradually improved; mental condition fair; no fits; able to leave bed; can walk all right, a little weak; complete power over functions of rectum and bladder; abdomen remains exceedingly tender; no pains: bowels constipated; pulse, respiration and temperature normal. Careful examination of heart reveals harsh first sound. Nothing in past history can be found to account for the seemingly epileptic state.

*June 3.*—Patient's gait very unsteady; staggers and sometimes almost falls down, especially when turning round; legs moved forward in a spastic state; can stand with eyes closed and heels approximated; great difficulty in walking backwards, in fact, performing any complex movement. Motor power in legs very much decreased, especially the right; sensation deficient. Great difficulty in locating seat of irritation; certain amount of analgesia; reflexes, deep and superficial, increased. Ankle clonus (?), found to be physiological. Has tenderness and œdema over sacro-dorsal articulation. Never had any difficulty in walking before admission.

*June 6.*—No improvement. Eyes examined by Dr. Buller; result negative.

*June 6-13.*—No improvement as regards walk. Condition of extremities remain unchanged. Complains of a severe pain

over hypogastric region, griping in character; suffered from this pain two weeks previous to admittance. Shooting pain up posterior part of both legs. Did not know patient's occupation at this time; but this constant abdominal tenderness and occasional griping, colicky pains, attended with constipation and indefinite nervous symptoms, directed attention to nature of occupation; immediately examined gums, and a most typical lead line was exposed to view. Believing all the symptoms due to lead poisoning, she was immediately given Potass. Iodide grs. x ter die.

*June 13 to July 1.*—A steady improvement has taken place in patient's gait, motor power, abdominal pains and tenderness; constipation remains to slight extent. Complains much of a coppery taste in mouth and great pain and tenderness over parotid region. Lead line very black, intense and extensive.

*July 14.*—Remained in hospital up to date. Improvement continues. Can walk without the least difficulty. Staggers little when turning round. Coppery taste in mouth. Still taking the iodide, and on a fair road to complete recovery.

CASE V.—*Plumbism—Source Unknown—Severe Colic.*

P. G., aged 52, sailor, sought admission into the hospital on 1st of June, 1885, complaining of pain over lower part of abdomen, griping in character and occurring in paroxysms, loss of flesh and obstipation. Has had several attacks of intermittent fever, likewise of gonorrhoea, the latter leaving a stricture easily dilated; patient using a No. 6 gum elastic catheter. Intemperate for many years past. Present attack commenced 2½ months ago with pain over hypogastric region, griping in character; relieved by pressure. Constipation of a severe type, requiring purgatives *ad libitum*. For instance, on one occasion, he took the following: a bottle of castor oil, a box of purgative pills, three doses of salts, and, to make sure of success, took the fourth dose of salts,—and, to use his own words, "it made him run." Has been losing flesh since March last—40 pounds. On admission a strong, seemingly healthy, well-developed Frenchman; complexion dark brown, simulating a

semi-icteroid condition; muscles soft, somewhat emaciated; tongue slightly coated and cracked, appetite diminished, no vomiting, bowels constipated; complains of this lower abdominal pain, griping in character, partially relieved by pressure; function of bladder normal, micturition not frequent; heart and lungs examined and found to be quite normal; pulse 72; respiration, 20; temperature, 98°; does not sleep well; no headache; partial loss of vision. Examination of eyes—Soft cataract, dark pigmentation of choroid; otherwise normal, Abdomen—No distention; palpation negative; no tenderness, with exception of hypogastric origin; liver extends one inch below costal margin. Urine, 1015 specific gravity; color light; deposit of lithates and phosphates; no albumen or sugar. With the above history and symptoms unable to come to a positive diagnosis. Treated the constipation, *Haustus Niger* ʒ iii at night; result good.

*June 2.*—Patient re-examined. Further consideration of the case suggested possible lead-poisoning. The gums being examined a deep, well-marked lead line was found in the usual situation. This fact, added to the symptoms already detailed, seemed conclusive. He was therefore given Potass. Iodide gr. x ter die., with a daily dose of *Mist. Alba* to relieve the constipation. *11th.*—Left hospital to-day. Pain has been absent for past four days; bowels regular; weight when admitted, 165 lbs.; exit weight, 170 lbs.; general condition good.

---

### Reviews and Notices of Books.

**Comparative Anatomy and Physiology.**—by F. JEFFREY BELL, M.A. Philadelphia: Lea Brothers & Co.

This is one of the series of manuals for students of medicine published by Cassels & Co. in England and Lea Brothers & Co. in America. As the title implies, it treats of both Comparative Anatomy and Physiology, the time not having yet arrived, as the author says, for the advent of a work on Comparative Physiology alone. The author has devoted his attention chiefly to such details of structure as have been fully substantiated by

experimental inquiry. The work is a description of organs rather than groups of animals, the more simple form of an organ being first described, and then the more complex, in this way showing that there has been an evolution of organs as well as of animals. After an introductory chapter, and one on Amœba, a description of the general structure of animals is given, and is followed by chapters devoted to the various organs, as of digestion, respiration, movement, reproduction, etc. Of course, in a small work of this kind, only a very short account can be given of the various parts of different groups of animals, but it will be useful to students going up for examination and those wishing to get a general view of the subject. The field is so extensive that it is useless to attempt to cover the whole ground in a work of one volume, but the author is to be congratulated on the way he has accomplished his task. The book is well printed and profusely illustrated.

**Diseases of the Tongue.**—By HENRY T. BUTLIN, F.R.C.S.  
Philadelphia: Lea Brothers & Co.

This, also, is one of the Cassels series of manuals published by Lea Brothers & Co. of Philadelphia. The author, Mr. Butlin, is already well known in connection not only with diseases of the tongue, but for his work on "Sarcoma and Carcinoma." When it was announced that he was to be the author of a manual on Diseases of the Tongue, it was felt that the task could not have been given into more competent hands. The work now before us, which is the result of years of experience and observation, fulfils all expectations, and is very complete. Every disease, accident and congenital defect to which the tongue is subject is ably described; and the treatment and operations for relief clearly and fully given. Over 100 pages are devoted to cancer of the tongue and its treatment. The various operations for removal of the tongue are noticed, and there are excellent chapters on the after-treatment and choice of operation. The author shows that the method of operating exercises infinitely less influence on the result than the after-treatment of the case. In uncomplicated cases he advocates extirpation of the tongue by

Baker's or Whitehead's methods, and in cases complicated with affections of the glands, Kocher's and Regnoli's methods or Billroth's modifications. In these latter methods the glands are removed through a separate incision in the neck, through which incision also the lingual only may at the same time be ligatured. Kocher, in addition, performs a preliminary tracheotomy. Mr. Butlin holds that preliminary ligature of the lingual does not in the smallest degree increase the danger of the operation. Billroth's method of after-treatment with iodoform gauze, as described by Wölfler, is strongly recommended. The only case, however, that the author treated in this way died of septic pneumonia. The 17 cases treated in Billroth's wards with iodoform gauze all recovered without any bad symptoms. We can heartily recommend this book to all practitioners desiring to know something about diseases of the tongue. It will prove as valuable to the physician as the surgeon. The book is well got up, and illustrated with engravings and chromo-lithographs.

**A System of Practical Medicine by American Authors.**—Edited by WILLIAM PEPPER, A.M., M.D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania; assisted by LOUIS STARR, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania. Vol. II. Philadelphia: Lea Bros. & Co.

The second volume of Pepper's System of Medicine forms a very handsome book of over 1300 pages, and in point of quality it continues in every way to deserve the high encomiums which have been passed upon its predecessor. In it the "General Diseases" are concluded by a description of those arising "from derangements of the normal processes of nutrition, viz., Rheumatism, Gout, Rachitis, Scurvy, Purpura, Diabetes Mellitus, Scrofula and Hereditary Syphilis." And this section is followed by the whole of the "Diseases of the Digestive System." The first article is on Rheumatism, including acute articular, sub-acute and chronic, muscular, gonorrhœal and rheumatoid arthritis, and is contributed by Dr. R. P. Howard of Montreal. It

covers the whole ground of this always interesting subject, gives all the most modern views of the pathology and causation, and furnishes copious references of great use to the earnest student for further research. The treatment of the various forms is fully dwelt on, and the more successful methods supported by the published reports of the most recent writers. On glancing over the list of the articles-furnished it will at once be seen that the most capable men in the country have been at work upon them. To select only a few from the many, Rickets receives full attention at the hands of Dr. Jacobi; Diabetes Mellitus has fallen to Dr. Tyson, who has already written a monograph on the same subject; Dr. Solis Cohen contributes the space allotted to Affections of the Mouth, Tongue, Tonsils, Pharynx and Œsophagus; Dr. J. Lewis Smith writes on Intestinal affections of Children in hot weather; Dr. Hunter McGuire on Intestinal Obstruction; Dr. Roberts Bartholow on Diseases of the Liver; and Dr. Alonzo Clarke on Peritonitis. It is but right to say that in every case each author would seem to have been determined to do full justice to the task set before him, so that when this work is complete, it will surely be looked upon as the standard and best exposition of the present state of the practice of medicine in America. The chief virtue of an index generally lies in its fulness; in this case perhaps the compiler has pushed this idea to an extreme degree, for it covers in itself over 100 pages!

**The Inhalation Treatment of Diseases of the Organs of Respiration, including Consumption.**—By A. HILL HASSALL, M.D., Lond., M.R.C.P., Eng., Founder of, and Consulting Physician to, the Royal National Hospital for Consumption and Diseases of the Chest, &c. With numerous illustrations. London: Longmans, Green & Co.

Of late years, renewed interest is being taken in the subject of the treatment of various affections of the lungs and air-passages by the direct introduction of medicaments through inhalation. The discovery of the bacillus of tuberculosis as a constant element in phthisical sputa and the good results following thorough antiseptic methods is sufficient to account for this.

There can be no doubt, therefore, that this exposition by an expert of his experience, with various applications of these principles, will be widely read. For it is well known that Dr. Hassall has for many years devoted great attention to the subject of pulmonary diseases, and has written several works upon the health resorts of Southern Europe. After considering the principles concerned in the volatilization and inhalation of medicaments, he discusses and describes the various forms of apparatus employed in diseases of the organs of respiration. The details of these are fully given, and numerous cuts are introduced to illustrate all those which have been found practically useful. This is followed by an interesting chapter upon "Inhalation Chambers." We then find a very full list of the various drugs, etc., which are employed for inhalation purposes, together with directions as to the quantities to be used, and the manner, frequency and duration of the inhalations. The whole is concluded by taking up *seriatim* the various diseases of the organs of respiration, and pointing out the best local treatment for each. No one can peruse this book without acquiring much useful knowledge, and feeling that, in neglecting this method of treatment, he is failing to arm himself with one of the most effectual weapons against a number of formidable enemies.

**A Practical Treatise on Urinary and Renal Diseases, including urinary deposits.** Illustrated by numerous cases and engravings.—By WM. ROBERTS, M.D., F.R.S., F.R.C.P., Lond., Professor of Medicine at the Victoria University, &c. ; assisted by ROBT. MAGUIRE, M.D., Lond., M.R.C.P., Lond., Physician to Out-patients, St. Mary's Hospital, Lond., &c. Fourth edition. Philadelphia: Lea Brothers & Co.

This well-known standard English work is now presented to the reading medical public in a considerably enlarged and otherwise much improved edition. Its first part is devoted to the physical and chemical properties of the urine, and to the various alterations which it undergoes under different circumstances of health and disease, in so far, and only in so far, as they seem

to have a practical bearing. The second treats of a group of affections which are often with propriety classed as "urinary diseases," viz., diabetes insipidus, diabetes mellitus, gravel and calculus, and chylous urine. The third is taken up with the organic diseases of the kidney, and constitutes the largest part of the work. Here, Bright's disease in its various forms is, as we should expect, treated of very fully. Complete, but shorter descriptions of all the other important affections of these organs are also to be found. Much new matter, as compared with the former editions, will be found in the chapters on albuminuria, on micro-organisms in the urine, etc., the latest observations on these important subjects being incorporated in the text. We know of hardly any work on urinary disorders more generally useful to the advanced student or to the practitioner for purposes of reference.

**Berlin as a Medical Centre: a Guide for American Practitioners and Students.**—By HORATIO R. BIGELOW, M.D. Sandy Hook, Conn. : New England Publishing Co.

This little work consists of a reprinted series of letters addressed from Berlin to the *New England Medical Monthly*. So many physicians and students from this side of the Atlantic avail themselves of the superior educational advantages of this great medical centre, that any assistance afforded them in the way of preliminary information will no doubt be received with gratitude. As the author says, probably with great truth, "very few professional men have ever gotten themselves into a good working routine, in Berlin, before spending a month or more in finding out about the courses they wish to take." It is, therefore, his main object to put all such in the way of avoiding this useless expenditure of time. He details the cost of travelling there with the routes which are preferable, gives lists of suitable hotels, restaurants and *pensions*, with the prices charged. Then follow well-arranged tables of all the principal lectures and clinics by the various professors and teachers. A number of other minor subjects also come in for a share of notice. If one were inclined

to criticize, perhaps exception might be taken to the minute directions given to intending travellers as to their requirements during the ocean voyage. They are informed that "a good travelling rug will be found of very general utility"—"a thick overcoat, gloves, and a slouch hat are never out of place"—"bromide of potassium is about the only satisfactory medicine that I know of in sea-sickness, and (alas! that it should require to be said) this often fails." This is twaddle, and would have been better away. Every one thinking of visiting medical Berlin will find it well worth his while to have a copy of Dr. Bigelow's letters.

**A Practical Treatise on Massage; its History, Mode of Application, Effects, Indications and Contra-indications.**—By DOUGLAS GRAHAM, M.D., Fellow of the Massachusetts Medical Society. New York: Wm. Wood & Co.

This work is a good illustration of how much can be written on a small subject. It contains nearly 300 pages. It is, in our opinion, an unfortunate circumstance that the author should not have condensed all he had to say in 100 pages, for in that space we feel confident he could have easily said all that any medical practitioner would be benefited by knowing on massage. As it is, the reader has to wade through a large amount of padding; and, further, subjects which have no direct connection with massage are dealt with. The clinical history and pathology of neuralgia, writer's cramp and rheumatoid arthritis are dealt with in an unnecessary length in a work which pretends to deal with massage solely. Thirty-one pages are devoted to the history of massage during the past 3,000 years—from the time that Homer in his *Odyssey* "tells us that beautiful women rubbed and anointed war-worn heroes to rest and refresh them"—from the time that "the Sicilian handmaid bathed high-hearted Laertes and anointed him with olive oil, and cast a fair mantle about him." Very full descriptions are given of the best methods of applying massage, and an attempt is made to give a physiological explanation of the good results obtainable by this means.

One of the best chapters in the book is on the treatment of the neurasthenia and anæmia of women. It is in this condition that massage, combined with rest and over-feeding, has done so much, especially in the hands of Weir Mitchell and Playfair, in curing apparently helplessly bed-ridden patients. The author cautions his readers not to expect a cure in all these cases, and he points out those that are likely to be benefited and those that are not.

After devoting a long chapter to the use of massage in affections of the central nervous system, the treatment of neuralgia and of peripheral paralysis are dealt with. Considering the otherwise encyclopædic character of the work, we were disappointed in finding so little said about the treatment of peripheral paralysis by this means. A word or two is said about a case of facial paralysis of several months' duration, arising from exposure to cold, that soon got well from massage. No mention is made of the electrical condition of the paralyzed muscles. In the absence of this evidence, the alleged cure by massage is of little worth, for it is an every-day observation that the milder forms of facial paralysis are soon recovered from without any aid.

There is an interesting chapter on massage in joint affections, including a biographical notice of Dal Cin, the notorious Italian "bone-setter" quack. The author has some sensible words concluding this chapter, which we quote: "The less people know, the greater is their faith, and hence the greater is their enthusiasm, which is so necessary to convince and carry along others. The most learned people outside of medicine are the most easily gulled, because they presume to know what they do not, and one assertion is as good as another with them. Child-like simplicity, good-natured enthusiasm, and unbounded sympathy are the three pre-requisites of a successful *magnetizer* or *bone-setter*, and the mysteriousness of their doings making a deep impression on their patrons, all other attributes are added to them. What is testimony worth under such circumstances."

---

### Books and Pamphlets Received.

SECOND REPORT OF THE STATE BOARD OF HEALTH OF THE STATE OF TENNESSEE. Nashville: Albert B. Tavel.

A PRACTICAL TREATISE ON DISEASES OF THE KIDNEYS AND URINARY DERANGEMENTS. By Charles Henry Ralfe, M.A., M.D. (Cantab). With illustrations. London: H. K. Lewis.

## Society Proceedings.

## MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, June 26th, 1885.*

T. J. ALLOWAY, M.D., 1ST VICE-PRESIDENT, IN THE CHAIR.

*Case of Extra-uterine Fœtation treated by Electricity.*—

DR. GARDNER read a paper on this case, which appeared in the August number of this JOURNAL.

*Discussion.*—DR. SHEPHERD said when he saw the case there were evidences of septic trouble. Tait says all these cases are tubal at first; he cuts down and removes the fœtus.

DR. HY. HOWARD said he had only seen one case of extra-uterine fœtation; it came to full term. The tumor was aspirated, followed in 24 hours by peritonitis, convulsions and death.

DR. WILKINS asked how the electricity caused the death of the fœtus; was it by exciting strong contractions of the muscular structures of the Fallopian tubes?

DR. KENNEDY said that he had seen two cases of extra-uterine fœtation. One of these had been reported to the Society some years ago. In this case the woman came to him about the fifth or sixth month to engage his services. Her appearance was normal, and she felt quite well. At the end of nine months he was sent for, as symptoms of labor had set in; on examination of the uterus, found it empty and the actual condition diagnosed. The case was explained to the patient and operation suggested, but she and her friends positively refused such assistance. The movements of the fœtus were quite lively up to this time, but ceased in a few days, and in a short time after, septic fever setting in, she was sent to the General Hospital. In the hospital she passed per rectum several foetal bones, sloughing having taken place between the sac and adjacent bowel. This patient died from septic poisoning, and the post-mortem confirmed the diagnosis previously made. The second case came under his notice eighteen months ago. He was asked to see in consultation a patient supposed to have pelvic cellulitis. After examining her, he coincided with the family doctor in this opinion, but

On a subsequent consultation he had come to the conclusion that the case was one of extra uterine foetation. Afterwards, during the absence of his *confrère*, he took charge of the case. The patient had been married before, and had two children by her first husband. The present husband was a strong, big man, with whom intercourse was generally painful. Previous to her illness she had thought herself pregnant, but the menstrual discharge had continued, somewhat altered from the usual flow when about  $3\frac{1}{2}$  months in gestation, and while dusting down the stairs, she was seized with a sudden severe pain in the abdomen, which almost caused her to faint. She was prescribed opiates and rest, and after a few days was up again. About ten days after, she had a second attack, and later a third. The last seizure was accompanied with a profuse flow and discharge of a membrane resembling the decidua. Abortion was supposed to have occurred, followed by pelvic inflammation. Although pelvic cellulitis was diagnosed, Dr. Kennedy has now no doubt that the primary condition was one of extra-uterine foetation; the character of the seizure and the subsequent symptoms being such as are observed in tubal pregnancy. Fortunately, death of the foetus no doubt ensued, and the subsequent inflammation had encysted its remains. This patient was a long time ill, but afterwards recovered. A tumor yet remains on the right side, and coitus is still painful.

DR. TRENHOLME had met with one well marked case where the foetus perished before its movements were felt. The patient becoming free from symptoms, went to the seaside, where she passed several small bones per rectum. There remained indications of induration. She has been in perfect health ever since. Another case he was called to see, where the foetus was as the sixth month. On examining the uterus, it measured 7 or 8 inches, was empty, but on the left side he found a bulging, and thought the case to be one of tubo-uterine foetation. He scraped over the bulged wall with a curette, and in 24 or 36 hours this was followed by expulsion of the foetus. He thinks the electricity kills from shock, not from exciting muscular contraction, as most likely the first seizure corresponded with the rupture of the tube, allowing the contents of the sac to fall into the abdomen, where there would be no muscles constricting it.

DR. ALLOWAY said he had read of a woman dying at the age of 75, and in whose abdomen foetal bones were found at the post-mortem examination. When 22 years of age she had had symptoms of extra-uterine pregnancy.

DR. GARDNER said that Tait found by examination that all cases were first tubal. Tait confines his operations to cases where rupture has occurred. Electricity is safe and simple to use. In this case electricity might have been used earlier. The electricity kills by shock to the child's heart. Most cases are right-sided. He believed there was not much doubt but that Dr. Kennedy's second case was one of extra-uterine pregnancy.

DR. GURD mentioned that their patient was doing well, being able now to take short walks.

DR. CAMERON asked if menstruation in this case had been abnormal. He had a case eight years ago where the woman suffered greatly at each period as if from inflammation of the Fallopian tubes. Might not these cases be caused by narrowing of the tube by contraction?

DR. GARDNER said this explanation was a feasible one.

DR. TRENHOLME said that a cellulitis with contracting bands might destroy the patency of the tube.

DR. WILKINS said that a chronic diseased condition might destroy the cilia of the mucous membrane of the tube, and so account for the fructified ovaries not being sent down into the uterus.

*Gynæcology.*—DR. LAPHORN SMITH read a short paper entitled "Notes on Gynæcology," being some observations made during a month's visit to the Women's Hospitals of New York. He began by referring to the great frequency with which the major gynæcological operations are performed, a frequency, however, which seemed to be generally justified by the results. Ovariectomies and hysterectomies were of daily occurrence, those of them which took place at the Woman's Hospital being performed in detached cottages, under the most perfect sanitary conditions. He thought that they were sometimes done in the face of fearful odds against success, the consequence being that the death rate was rather high. He spoke of the skill and cool-

ness of the operators, and the splendid training of the assistants and nurses. Although the operations were not done antiseptically in the strictest sense, yet every precaution was taken to insure cleanliness. Dr. Hunter takes especial care not to allow a single drop of blood to enter the peritoneal cavity when performing hysterectomy; the peritoneum not being opened until all bleeding from the incision in the abdominal wall had been arrested. When the uterine tumor has been drawn through the opening, it is immediately wrapped in a carbolized towel, in which it is held, and the edges of the wound are enfolded in warm carbolized towels. Ether was the only anæsthetic used. The operations for lacerated cervix and lacerated perineum are performed with still greater frequency; the former being done not only for the purpose of closing the rent, but still more often as a rapid method of removing the hypertrophy and inflammatory exudation of subinvolution. The operator made it a rule to be satisfied with nothing short of the complete removal of the cysts formed by the diseased nabothian glands, digging down and removing indurated tissue almost as far as the internal os. The needles used were short, round, and slightly curved, having one surface ground flat near the point; and for sutures, a No. 26 pure silver wire attached to the end of a plaited silk thread was generally employed. The operation for lacerated perineum is also very frequently done; in many cases for the cure of rectocele and displacements of the uterus. The reader stated that he frequently met with cases of prolapsus uteri in his practice, in which the vulva was so large that no form of ring pessary could be retained; all such cases were suitable for operating. He also remarked that in these two operations the scissors and tenaculum have completely taken the place of the knife and forceps. Two other instruments which he found in general use were the Wylie dilator and the Thomas' blunt curette, their advantages and immunity from danger he set forth at some length; nevertheless, it is better to keep the patient anæsthetized. The reader then related the various uses to which the tamponnade of the vagina or columning is put to, and stated that it has very largely taken the place of solid pessaries, especially where there

is an inflammation in or about the displaced organ. He stated that the introduction of cotton tampons soaked in glycerine or glycerine of tannin and the use of the hot-water douche have marked a new era in the treatment of pelvic cellulitis, subinvolution of the uterus, and other inflammatory affections of the generative organs. He concluded by describing a case under Emmet's care, in which that distinguished operator had intentionally made a vesico-vaginal fistula for the cure of chronic cystitis which had been otherwise intractable. After three or four months the cystitis was cured, and he closed the fistula without much difficulty.

---

### Extracts from British and Foreign Journals.

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

**Pent-up Secretions.**—Mr. Wheelhouse illustrates a most interesting lecture on the subject of "pent-up secretions" by typical cases showing the way in which most distressing symptoms may sometimes be relieved, if it be discovered that some secretion is pent up, and this secretion be evacuated. The case of a young gentleman is narrated, to whom the author was called, and found on the point of suffocation. On physical examination it was discovered that the left pleura was full of fluid. A Roberts's trocar was thrust into the side, and six pints of clear fluid were withdrawn, giving instant relief. Another time, Dr. Clifford Allbutt called the author to a case of acute rheumatic fever. The patient was dying from acute pericardial effusion; a small trocar and canula was thrust along the upper margin of the fourth left rib, the serum was drawn off, and the patient soon recovered. A third case is given in outline, where a young lady of wealth, living in a mansion surrounded by everything conducive to health, yet constantly suffered from what was supposed to be well-marked blood-poisoning. At length the patient's regular medical attendant decided to enquire fully into the question of the "periods," and on examining a diaper found that there was only a small amount of "foetid" discharge upon it. A second

opinion was obtained, and an examination, under ether, was insisted upon. It was then found that the patient had a hymen so nearly perfect, that only a tiny aperture existed to permit the exit of the natural excretion. On freely dividing the membrane, the vagina was found converted into a distended sac, its walls being granular and over-vascular, thus presenting a very large absorbing surface. A few months sufficed to make a complete and perfect cure of all her troubles. The most remarkable advance made in the treatment of cases of phthisis is the method of opening phthisical cavities through the back, and draining them by means of drainage-tubes, thus relieving the cough and foetid expectoration.—*British Medical Journal*, January, 1885.

**The Treatment of Fever as a Symptom.**—While the chief object of all medical treatment is necessarily to eradicate disease by attacking its very beginnings, there are times in which the relief of a pressing symptom may constitute the first important step towards recovery. Fever is such a symptom. How often does one find that, even in the presence of an active morbid cause, the mere remission of temperature for a certain period assists the physician, by obtaining rest for his patient, by gaining time, by quieting irritability in the neighborhood of a source of mischief, and so converting an acute into a subacute or chronic process. These effects appear in many diseases which are said to run an unvarying course—in typhoid fever and early tuberculosis, for example; and there are good physiological reasons why the abatement of fever in itself should materially aid and tide over other efforts of nature or of art, which are designed to cut the root of unhealthy action. It becomes, therefore, a matter of interest to enquire in what way a fall of temperature can thus react upon the local processes which determine the course of fever, and that fever does not depend on local causes may probably be accepted as an axiom. All its features tend to show that it is a nervous disorder which acts along the lines of the vaso-motor system, that its method is reflex, and its results a

destructive metabolism, which reveals itself in general emaciation, and is most intense at the original seats of morbid irritation. The aim of antipyretic measures must therefore be to allay this nervous overwork by opposing a buffer to the repeated shocks of peripheral stimuli, and this may clearly be accomplished in more ways than one. Thus it is frequently possible, by using narcotics, to lull the excited cerebro-spinal centres generally, and so to weaken their response to provocation. By another agency the constricting influence of the vaso-motor centre may be specially and directly inhibited and the circulatory system proportionately eased, as would seem to be the case when salicylates are employed. In this case, also, the harassed nervous centres share the general rest. The heat-regulating mechanism, too, if it exist as a separate factor, may be restrained by similar means, when its disordered forces would otherwise result in riotous excess of tissue change. In any case, the reduction of fever, beside preventing general loss of power and substance by wasteful molecular action, is directly beneficial in another way. By depleting areas which border on the causal irritant or its habitat, and the intense congestion of which magnifies the force of stimulation, it must react as a sedative at the very source of disease. These observations suffice to show why antipyretics possess a real value even in such diseases as continuous fevers. Apart from the aid they render to the further resources of medical skill, and apart from their action on septic germs, they often appear, by the rest which they procure alone, to constitute the chief element in the cure of febrile disease.—*Lancet*, June 6, 1885.

**Pyridine.**—M. Germain Sée, in a communication to the Académie des Sciences on pyridine, states that neither subcutaneous injections of pyridine salts, nor smoking cigarettes of pure pyridine, offered the same advantages in asthma as the practice of administering it by inhalation. Four or five grammes are poured on to a plate, which is placed in a closed room containing rather less than twenty-five cubic metres of air. The patient, in the room, breathes the air impregnated with pyri-

dine. This treatment should be repeated, for about twenty minutes, three times a day. Pyridine can be traced in the urine almost immediately after the commencement of an inhalation. According to Dr. Germain Sée, hypodermic injection and pyridine cigarettes provoke nervous disturbance. Inhalation produces a beneficial effect; the feeling of oppression common among asthmatic patients being relieved, breathing becomes easier, and they have no longer the characteristic intense longing for fresh air. The sensibility of the pneumogastric nerve and the excitability of the medulla are considerably diminished, and the heart's action becomes normal. It frequently happens that the patients fall asleep after the inhalations. This sleep is almost normal, and is not accompanied by profound insensibility, and is therefore different from that provoked by anæsthetics. While it lasts, sensations, followed by reflex phenomena, are provoked with difficulty, although contractile energy is maintained. The administration of pyridine is not followed either by paralysis, convulsions or tremors; but the muscles are relaxed and temporarily lose their tonicity in consequence of the lessened sensibility of the medulla oblongata and spinal cord. This modification of the reflex sensibility is the especial characteristic of pyridine, as distinguished from substances like nicotine and atropine.

All the patients to whom Dr. Sée administered pyridine had quiet nights, though previously tormented with violent fits of coughing and intense oppression. The physical pulmonary symptoms all showed improvements. Pyridine does not affect the general health. When the suffocating asthmatic fits reappear after inhalations for nine or ten days, Dr. Sée recommends the administration of iodides. He has treated fourteen patients, nine of whom were asthmatic and five subject to cardiac diseases; they were all relieved. One patient had suffered from asthma for twelve years; he was greatly relieved by the treatment with pyridine, but it was discontinued in consequence of troublesome attacks of vertigo and sickness. The asthmatic patients who presented cardiac and renal complications, declared that respiration was much eased by the inhala-

tions. Dr. Sée concludes that pyridine is preferable to hypodermic injections of morphia, its action being preferable and less dangerous.—*Paris Correspondence of British Medical Journal.*

**Removal of a Calculus from the Vermiform Appendix** FOR THE RELIEF OF RECURRENT TYPHLITIS.—At a recent meeting of the Clinical Society of London (*Medical Press*, May 13, 1885), Dr. Symonds read the history of a case in which, at the suggestion of the late Dr. Mahomed, he had removed a calculus from the vermiform appendix for the relief of recurrent typhlitis. A basket-maker, aged twenty-three, was admitted to Guy's Hospital July 16, 1883. Six months previously he was seized during the night with pain in the right iliac region; this increased in severity and he became ill generally, and at the end of a week was unconscious, remaining in this state four days. The illness lasted seven weeks. During the first week he vomited everything, and his bowels were not opened for ten days. During the whole time there was great tenderness in the right iliac fossa. During the first part of his illness he was under the care of the parish, and for the last two weeks was in the Camberwell Infirmary, where he was told he had typhlitis. Soon after this, on getting about, he noticed a hard lump in the right groin about the size of a walnut; sometimes this swelling was painless, at other times it was very tender. Since this illness he has had repeated attacks of pain in the right iliac fossa, which come on suddenly, and last one or two days. The pain is relieved by poultices. At first these attacks recurred about once a month, but during the last five weeks he has had six attacks, and they have been increasing in severity. One of the attacks having been observed in the hospital, it was proposed that the cæcal region should be approached by an incision in the right iliac region. Dr. Mahomed was of the opinion that there existed an abscess cavity containing probably a calculus or concretion, and that the periodical occlusion of a communication with the cæcum determined the recurrence of pain. It was finally decided to

cut down upon the small hard lump which was to be felt in the right groin on deep palpation. On August 24th chloroform was administered, and under the carbolic spray an incision was made, commencing two inches above and one inch internal to the anterior superior iliac spine, and curving downward and forward for about four inches, being much the same as that used in ligature of the external iliac, and so arranged that its centre corresponded with the position of the lump. The various structures were divided, but the transverse fascia was not distinctly recognized, owing possibly to the incision being rather near the iliac spine. The structures in front were now raised out of the iliac fossa, when the lump could be plainly felt from behind, and as yet the peritoneal cavity had not been opened. A hand pressed deeply from the front steadied the swelling, and brought it more into the wound. A vertical incision was now made over the hard lump, and a small calculus exposed. Before removing it a fine silk suture was passed through the tissues just above, so that the orifice might not be lost. The opening was then enlarged, and the calculus removed. The soft and purple mucous membrane of the appendix was seen, and its tortuous course from the aperture could be traced upward toward the cæcum, so that there seemed no doubt of the canal having opened. Exploration of the cavity with a probe failed to detect a channel leading toward the cæcum. No pus or other fluid was found round the calculus, nor was there any fecal or unpleasant odor. The opening into the appendix was closed by Lembert's and the wound by deep silk sutures. The peritoneum was not opened, so far as could be determined, and this was attributed to the adhesions that had probably taken place at the time of the first attack, and to the method adopted in reaching the appendix. The usual gauze dressings were used. The calculus was oval in shape, smooth on the surface, and measured three-fourths of an inch long, and rather more than one-half of an inch wide. On section it showed a laminated calcareous capsule enclosing hardened fecal matter. The patient made a somewhat protracted but complete recovery, and in April, 1885, although an

inmate of a lunatic asylum, it was learned that he had never had any bowel trouble since November, 1883. In his remarks on this case, Dr. Symonds points out that this is the first case in which a concretion or calculus has been removed from the appendix vermiformis without, at the same time, the opening of an abscess. He says also that the credit of the procedure must be given to Dr. Mahomed, at whose suggestion the operation was undertaken.

**Transmission of Syphilis by the Hebraic Rite of Circumcision.**—Dr. A. Kedotoff cites three cases of this character, in the first two of which mother and child both suffered from the infection. This operation has been so frequently described as to make it unnecessary to repeat it here, except to say that after the foreskin has been removed the wound is sucked by an assistant. It is certain that if the psylle be syphilitic, the chances are very great for the contamination of the child, recognizing the frequency of buccal chancres.

In the three cases cited there was no question of hereditary syphilis, because in the first two the fathers were carefully examined, and showed no traces of the disease, and the other children were exempt. In the first two there were traces of the primary sore on the penis. If the hereditary influence be admitted, it is difficult to understand how the children could so infect their mothers. The operator being examined, was found to be perfectly healthy. The psylle (or the assistant whose business it was to suck the wounds) showed no blotches or cicatrices upon his body. The cervical, epitroclear and inguinal glands were slightly tumefied. No trace of syphilis on the genital organs or about the anus. But on the mucous membrane of the lower lip there was a curvilinear cicatrix passing to the gingival ridge, where there was a pearly spot, which was covered by the thickened, whitish, opaline epithelium. On the mucous membrane of the upper lip, there was a yellowish fissure, and on the gum opposite to it a little greyish spot, as if covered with false membrane, and which looked like a mucous

patch; the tonsils were slightly injected. The psylle denied that he had had syphilis, and explained the presence of the cicatrix on the lip as due to a fall in childhood. One suspicious circumstance connected with the case was, that the operator presented himself for examination without hesitation, while the psylle refused to come until brought by the police. A month later he was examined by two other physicians, who confirmed the presence of these symptoms, but were doubtful as to their origin. Dr. Kedotoff considers that the psylle contracted the disease less than five years before, possibly in another way than by coitus, and that the affection showed itself in a slight, benign form, which manifested itself, from time to time, as mucous patches—the form most apt to transmit infection. Moreover, it is this form which most frequently escapes attention.—*Ann. de Dermatol et de Syphil.*, Vol. V., Nos. 9-10.—*Jour. Am. Med. Ass.*

### **Nervous Symptoms of Enteric Fever.—**

The following are the conclusions reached in an article by Dr. J. C. Wilson, published in *Medical Times* :—

1. The so-called typhoid condition (stupor, somnolence, hebetude, prostration) is dependent upon the alteration of the blood caused by the infecting principle. It may be said that the intensity of these symptoms is proportionate to the virulence of the infection.

2. Delirium (especially when violent) and agitation, in a word the ataxic phenomena, are produced by the same pathogenic principle. But their manner of development and their course are to a great degree influenced by the pyrexia. The fact, however, must not be overlooked that certain forms of delirium occurring in enteric fever are not dependent upon the elevation of the temperature.

3. Certain forms of delirium, especially delirium ceasing after free epistaxis, and certain muscular disorders, such as convulsions and contractures, must be ascribed to hyperæmia. Disturbances of sensation are likewise in many instances the result of congestion of the nervous centres.

4. Vertigo, delirium, etc., may also be due to anæmia, which plays an important part in the production of enfeeblement of the central nervous system. Collapse is very often due to abundant hemorrhages. Inanition, producing, as it does, a profound denutrition, is a cause of anæmia, and favors the collapse and marasmus, which are so often fatal.

In conclusion, whilst intense pyrexia is the cause of serious symptoms and grave complications, it is possible to assign to it a high position as a pathogenic factor. The dictum of Griesinger, "The fever in great part controls the situation,"—*Das Fieber beherrscht zu grossem Theil die Situation*—has exposed those who have accepted it to grave therapeutic errors. The nervous phenomena of enteric fever are produced by various causes which act sometimes together, sometimes separately. It is not easy to discover the predominant element in a pathology always complex, nor is it desirable to carry the analysis to an extreme. From a clinical standpoint, however, the subject is important, for the management of the nervous symptoms will be successful in proportion as their interpretation is exact.

### **Experimental Investigations concerning the causes of Diphtheria.**

—By Pintschorius of Ketzin (*Jahr. f. Kinder.*, B. XXII., Hft. 4, from *Allg. Med. Central Zeitung*).—For inoculation material the author used portions of the soil of a house in which there had been several cases of severe diphtheria. A hole was dug in the cellar, and into it was poured urine free from bacteria. After nine days a portion of the urine-infiltrated soil was removed, and with it was mingled fresh urine which was allowed to filter through it. After drying this mixture, some of it was rubbed upon the gums of chickens, which had been freshly abraded for this purpose. Diphtheritic patches resulted upon the surface of inoculation with severe febrile symptoms. False membranes were also formed in the trachea. Inoculation with the membranes thus formed resulted in the development of well-marked diphtheria. A similar result was obtained by the inoculation of membrane removed from diphtheritic children. The conclusion from these

experiments is that bacteria from soil which is impregnated with the products of putrefaction are the cause of diphtheria. The author also believes that it has been shown that the spores of fungi are held in ground air, and that they ascend in the walls of houses to the warmed spaces by means of the current of air which the heat produces. The spores are round, have sharp contours, and no nuclei.—*Archives of Pediatrics.*

**External Use of Chloroform in Difficult Labor.**—Dr. A. Svanberg recommends the external application of chloroform to the abdomen in cases where labor is delayed or obstetric manipulations prevented by uterine rigidity. By this means he has succeeded in turning, several hours after the escape of the waters, and also in removing retained placenta without resorting to the inhalation of an anæsthetic. He soaks a piece of flannel in equal parts of sweet oil and chloroform, and then places it on the abdomen between the symphysis and umbilicus, keeping it in close contact with the skin for about five minutes. If the case be a severe one, the flannel is to be soaked again and reapplied for a few minutes more; at the end of about ten minutes the rigidity was always found to have disappeared, so that the necessary manipulations could be performed without any trouble.—*Chicago Medical Journal and Examiner.*

**On the Surgical Treatment of Asthmatic Conditions.**—Hack of Freiburg, speaking before the Medical Congress at Wiesbaden (April 11, '85), communicated his experience of nearly 600 cases of asthmatic conditions (*Beilage zum Centralb. f. kl. M.*, No. 20, 1885). In all these cases a reflex neurosis could be found, either present or having existed some time previous. The nose was invariably the centre of the reflex irritation. In 81 cases in which nasal obstruction alone called for surgical interference, it became evident that, with the increase of chronic hyperplastic rhinitis, all neurotic conditions, especially asthma, in spite of long existence, had disappeared spontaneously. Hack holds that reflex neuroses may

originate whenever the nose is the seat of hyperplastic conditions. In cases where the mucous membrane alone is affected, the usual catarrhal treatment with astringents and stimulants ordinarily suffices to suppress the neurosis, while neuroses depending upon hyperplasia of the deeper cavernous structures invariably require surgical attendance—*i.e.*, destruction of the cavernous tissues.

**Poisonings in 1883.**—The Registrar-General's Report for 1883 has lately been published. This report concerns England and Wales only, and it appears that the total number of deaths registered during 1883 reached 522,997; of these 639 are attributed to poison. Further classifying these it seems that 374 (239 males and 135 females) were due to accident or negligence; 264 (163 males and 101 females) to suicide, and 1 (a male infant under one month old) to murder. Opium, or one of its preparations, is given as the agent in this case. Of the accidental deaths, 93 occurred to children under five years of age. Lucifer matches, water hemlock, and benzoline, each caused 3 deaths; paraffin, poisonous herbs, vegetable poisons, poisonous fish, liniment, improper food, oil of juniper, medicine (kind not stated), yew, poisonous berries, each caused 2 deaths. Iodine, tartaric acid, Woodward's gripe-water, drugs to procure abortion, green paint, diseased meat, cayenne pepper, syrup of rhubarb (!), croton oil, nitre balls, copper, hydrate of tin (tinned salmon) and mushrooms caused 1 death each,—all classed as accidental. For suicides, the following poisons were also selected, one each: Chloride of zinc, atropine, bichloride of iron, bichromate of potash, lime, and salts of lemon. There are several comments which might be made on these statistics, but the most noticeable fact of all appears to us to be the high high place in the table taken by carbolic acid.—*Chemist and Druggist.*

**The Intravenous Injection of Milk.**—Having recently injected milk into the veins of a person about to die, who survived for some hours after the operation, and believing that this therapeutic measure is one of great value as a substitute for the transfusion of blood, Mr. Charles E. Jennings

(*Brit. Med. Journal*, June 6, 1885) has made a careful study of the subject, from which physiological, experimental, and clinical evidence combined he has drawn the following conclusions :

1. The intravenous injection of a small quantity of newly-drawn milk is harmless.

2. Large injections of milk are fatal, with polyuria as the chief symptom.

3. The employment of impure or stale milk is most dangerous, on the probability that septicæmia will follow the operation.

4. The operation is to be recommended in the later stages of cholera, enteric fever, phthisis, and pernicious anæmia, as a substitute for the transfusion of blood ; and, in short, in all cases where transfusion of blood is indicated on nutritive grounds, but where a blood-donor cannot be procured, or where this operation is, for other reasons, impracticable.—*Therapeutic Gazette*.

**Cod-Liver Oil and Lime Water in Scalded Throat.**—A child, aged 3 years, scalded the throat severely in attempting to drink from the spout of a boiling tea-kettle. When seen a few hours later she was in a state of collapse, and the tissues about the mouth greatly swelled. Equal parts of lime-water and cod-liver oil were given in tea-spoonful doses every hour. It was found to act beneficially by its local effects, and also served as nutriment for the child. In three days there was great improvement, consciousness returned, and in a week the distressing dyspnoea, which had threatened life, passed away. Milk was gradually added to the oil and lime water, and the case recovered completely.—*Lond. Practitioner*.

**Reunion of Separated Members.**—Dr. Klein, of the Austrian army, reports two cases of perfect reunion after separation of members, which clearly demonstrate that the preservation of separated members in alcohol is not the sole office of the surgeon in such accidents. Both cases referred to self-inflicted amputation of fingers to avoid military service. In one case union resulted in 22 days ; in the other, where the finger was only found half an hour after the amputation, the cold and blue member grew warm on the second day, and had re-established its former relations completely within six weeks. Iodoform gauze was used in both cases.—*Wien. Med. Woch. ; Therapeutic Gazette*.

CANADA

# Medical and Surgical Journal.

MONTREAL, SEPT., 1885.

## REPORTING CONTAGIOUS DISEASE.

In view of the increasing prevalence of smallpox in this city, the health authorities determined to bring before the courts some case coming under their notice in which a physician should have failed to report the address of a smallpox patient under his care. On the 7th of August, Dr. Jacques was summoned to appear before the Recorder, charged with the above offence. The action was taken under section 37 of the City By-law 105 as follows: "All doctors practising within the city limits are required to report within 24 hours all cases of smallpox, typhoid fever, diphtheria, or any other contagious disease which may come under their notice, and give notice to the Health Department of the name of the person, the number of the house, and name of the street where the disease exists." The facts were admitted, but the accused pleaded that, notwithstanding knowledge of the by-law, he had considered any such attendance a professional secret, that it was privileged, and that he should not be bound to divulge the nature of any patient's illness. The oath taken at graduation was invoked to support this view of the case. His Honor the Recorder, in delivering judgment, declared that the Provincial Legislature, which enacted the above clause, had full power to do so, and that, as long as it stood upon the statute-book, all were bound to obey it. The Hippocratic oath he could not believe to cover the case in question, for the obligation to professional secrecy contained the proviso, "*non sine gravi causâ*"; and, the grave cause—the urgent reason—here lay in the existence of a rapidly-spreading contagious disease in our

midst. On these grounds, Dr. Jacques was pronounced guilty under the by-law, but in view of its being the first conviction, and that the doctor was believed to have acted in good faith, sentence was suspended.

It is clear that the Board of Health are determined to enforce this provision for the reporting of smallpox, and our city physicians, to avoid trouble, must govern themselves accordingly. When the by-law was before Parliament, it was discussed at the Medico-Chirurgical Society, and many objections were urged against it—several of the oldest and most influential members declaring that they would never consent to abide by it. The objections to it are sufficiently obvious; it is very distasteful to medical men to feel that they are called upon to act the spy, and perform an act which may be very repugnant to their patients; and it does seem to forcibly break through that proper reticence which is observed by every careful physician concerning the private affairs of the families under his care. The objections are very forcible—so forcible that we do not think these reports will ever be furnished cheerfully. We doubt still (for we ventured an opinion on the subject some time ago) whether this conviction will have as good an effect as might have been obtained by a strong circular from the chairman to the members of the profession, urging their co-operation in the matter. It is still our opinion that the Board of Health is entitled to have instant reports of every case of smallpox, but we also still consider that this duty should be made to fall upon the citizens and not upon the physicians. We might well copy laws in force elsewhere, by which the householder, head of family, or landlord, &c., is bound to send in the required notification. We hope some day to see a modification of the by-law introduced to that effect.

#### CANADA MEDICAL ASSOCIATION.

We would again remind our readers that this Association meets in Chatham, Ont., on Wednesday and Thursday, 2nd and 3rd of September. As will be seen, the number and character of the communications are such as to ensure the scientific suc-

cess of this meeting. It is to be hoped that the members of the profession throughout the length and breadth of the land will avail themselves of this opportunity of practically benefiting themselves and at the same time enjoying a short holiday. The proportion of practitioners attending our annual Association should be much larger than it is. No man can attend these gatherings in a proper spirit without coming away greatly benefited by what he has heard and seen.

The following are the papers promised up to August 19th :—

1. Dr. William Osler (Philadelphia). The Clinical and Pathological Relations of the Cæcum and Appendix.
2. Dr. James A. Grant (Ottawa)..... Aortic Aneurism.
3. Dr. W. B. Geikie (Toronto) ..... Retroversion of the Gravid Uterus.
4. Dr. Burt (Paris):..... Internal Urethrotomy.
5. Dr. Holmes (Chatham) ..... Observations on Puerperal Mania
6. Dr. Kerr (Winnipeg)..... Fractures in the Neighborhood of Joints.
7. Dr. Fenwick (Montreal) ..... Amputation of the Breast, with Cases.
8. Dr. Bethune (Wingham) ..... Exhibition of Specimens:
  - a. Parasite from an Abscess of the Thigh.
  - b. Aneurism of the Pulmonary Artery.
9. Dr. Worthington (Clinton)..... Epidemic Cerebro-Spinal Meningitis
10. Dr. Fulton (Toronto)..... Subperiosteal Amputation.
11. Dr. Campbell (Scaforth)..... An Account of a Case of Trephining the Mastoid Bone.
12. Dr. Rutherford (Chatham)..... Supra-Pubic Urination.
13. Dr. Stephen Lett (Homewood } Inebriety, a Disease the result of  
Retreat, Guelph)..... { Physical Causes.
14. Dr. A. H. Wright (Toronto)..... Phlegmasia Dolens.
15. Dr. McKeough (Chatham)..... Observations on the Use of Pilocarpine in Puerperal Eclampsia.
16. Dr. J. E. Graham (Toronto)..... Case of Dissecting Aneurism of the Thoracic and Abdominal Aorta, with specimens.
17. Dr. Shepherd (Montreal)..... Excision of the Tongue, with preliminary Ligature of the Linguals.
18. Dr. Alloway (Montreal)..... Micro-Organisms in Puerperal Septicæmia—Prophylaxis and Treatment.
19. Dr. Ryerson (Toronto)..... 1. Surgical work in the late Rebellion.  
2. Atrophic Nasal Catarrh.
20. Dr. Atherton (Toronto)..... Notes on two cases of Abdominal Section for Uterine Myomata.

21. Dr. Nattress (Toronto).....Field Hospitals and Climate in the North-West Territory.
22. Dr. Gardner (Montreal) .....History of a case of Double Uterus, with exhibition of the specimen.
23. Dr. A. E. Hanna (Lansdowne)...Enlarged Prostate.
24. Dr. Oldright (Toronto).....A few notes on a Case of Pernicious Anæmia.
25. Dr. Ames (Brigden, Ont.).....The Bite of a Rattlesnake.
26. Dr. Wilkins (Montreal) .....Exhibitions of specimens (macroscopical and microscopical) illustrating the infective nature of Tuberculosis.
27. Dr. Stewart (Montreal).....The Curability of cases of the chronic form of Infantile Paralysis.
28. Dr. Geo. W. Major (Montreal)....Possible Complications of Naso-Pharyngeal Operations.
29. Dr. Arnott (London).....Sources of Malaria.
30. Dr. Hingston (Montreal) .....Nephrotomy, with cases.

—It has been thought advisable to bring this JOURNAL into line with the majority of the monthlies which appear on the 1st of the month. For the future, therefore, we hope to present our JOURNAL on the 1st instead of on the 15th as hitherto.

DR. STEWART.—Our readers will notice that we have secured the co-operation of Prof. James Stewart in the work of editing this JOURNAL. The addition thus made to our staff will no doubt result in improvement in many directions, for the ability, energy and literary tendencies of Dr. Stewart are well known to all.

—Smallpox is rapidly spreading in Montreal. It is stated that already 120 deaths have occurred, which number must, of course, correspond with at least four times as many cases. The Civic Hospital has for days been more than full, patients having even been put in upper rooms, quite unfit for the purpose. The Board of Health, with commendable energy, are engaged in the erection of a second building, which will probably be amply sufficient. The fear is, that the haste with which the construction is being carried on will necessitate very poor work. We never heard any good reason given for the tearing down of the wooden building used in the last epidemic.

The utter failure of our local supply of vaccine just as smallpox took hold upon us was a public calamity. It has de-

layed vaccination throughout the city, and has given ground for those opposed to the principle to urge their fears of the quality of the lymph. Vaccine which is giving good satisfaction is being regularly supplied from Boston and elsewhere, and there is no reason for any being deprived of this invaluable protective.

—It is proposed by a committee of distinguished physicians in Florence to collect subscriptions for a memorial to the late Prof. Pacini, the distinguished Italian anatomist. The following circular has been issued, and is a handsome tribute in itself to the memory of the great scientist:—

‘Honor to the memory of a great citizen, destined to remind posterity of his virtues and his labors, is a duty which the nation that gave him birth is bound to discharge. From such men proceeds an example which acts as a noble oration, preaching great deeds to future generations. Italy has such a duty to perform in memory of Phillip Pacini, who discovered the tactile corpuscles, who, since 1854, has devoted himself to profound and original researches on the specific nature of Asiatic cholera, and who has introduced a method of artificial respiration which repeated experiments have proved to be the best for saving life. It is for Italians, then, to perpetuate the fame of this man, who, springing from a humble origin, has succeeded, by force of will, in gaining universal renown in anatomy and biology; who, after a life of exemplary activity, in the course of which he never thought of his own interests, but rather considered the welfare of humanity, died poor, leaving to his successors nought but certain precious documents of high merit, such as the ‘Structure of the Retina,’ ‘The Electrical Organ of the Gymnotus,’ and ‘The Extra-Vascular Circulation of the Blood.’”

### Obituary.

PROF. MILNE-EDWARDS.—The death of this distinguished scientist has just been announced, at the advanced age of 88. He was born at Bruges, in Belgium, and studied medicine in Paris. In 1841 he was elected Professor at the Jardin des Plantes, eventually succeeding Geoffrey St. Hilaire. His services to science are well known. His most important contributions are contained in the twelve volumes of his *Leçons sur la Physiologie et l'Anatomie comparée de l'Homme et des Animaux*.

## Medical Items.

—During the past summer session there were 5,122 students in the University of Vienna. Of this number 2,310 were medicals.

—Drs. Leube, Liebermeister and Lichtheim have each been named as the probable successor of Prof. Gerhardt, who has recently been translated from the Wurzburg to the Berlin Medical Klinik.

—Dr. T. W. Mills, who has been lately engaged in a very important series of original researches at the Marine Zoological Laboratory at Beauport, North Carolina, has returned to continue his investigations at the Johns-Hopkins University, Baltimore.

—A curious fraud is reported to have been perpetrated near Buxton. One William Mellor became ill, and was attended by a medical man. On recovery, he shaved his beard and otherwise altered his appearance, presented himself to the doctor as the brother of the sick man, and announced the death of the patient. Acting on this information, the doctor gave a certificate, which enabled Mr. Mellor to register his own death, and draw his burial money from a benefit society. He then made off, and has perhaps gone to die in some other part of the country in a manner equally advantageous to himself.

**BELLADONNA IN THE TREATMENT OF INTESTINAL OBSTRUCTION.**—Dr. T. J. Hudson (*Med. Times and Gazette*) thinks that in these cases the best way to use belladonna is to apply the extract to the abdomen with very hot poultices, and to give one or two grains of the extract as a suppository every hour, or inject 1-120 of a grain of atropine every two hours until slight dilatation of the pupil is maintained. If the pain continues, and is serious, an injection of 1-80 of a grain of atropine, with  $\frac{1}{3}$  of a grain of morphinn, is the best, as it combats depression and nausea. Morphine alone often increases the obstruction by causing or increasing nausea and, in the early stage of intussus-

ception, preventing the bowel from righting itself by its own muscular power. He adds the caution that lime-water should not be given, as it decomposes atropine.

DEATHS FROM POISONING BY WILD HONEY.—At Branchville, S.C., on June 5, a large number of persons, three of whom died, were poisoned by eating wild honey. Shortly after taking it they all complained of blindness and dizziness, and the honey was found on examination to be strongly impregnated with gelsemium. But for prompt and energetic medical assistance, it is said there would have been twenty deaths instead of three. A few days before, there occurred two deaths in the neighborhood which could not be satisfactorily accounted for, but which are now believed to have been undoubtedly due to the same cause.—*Gaillard's Med. Journal.*

HOW TO AVOID NIGHT CALLS.—A story is going the rounds (who started it we do not know) at the expense of the young physician who is always so busy that he doesn't know what to do. "I've got more business than I can attend to," boasted he to an old practitioner who knew he lied. "I had to get out of bed five times last night." "Why don't you buy some insect powder?" quietly asked the old doctor.—*Medical Age.*

A FASHIONABLE AMUSEMENT.—An English medical paper says that "the care of babies has become quite a fashionable amusement among mothers," and attributes this growth of maternal solicitude to the innumerable "guides to nursing" published in England of late. In connection with this statement, the following item from the *Providence Journal* may be of interest: Among the returns of death last month in this city was one of a young child, the cause of which was given by the physician thus: Cause of death—"How to Feed the Baby" and its Boston author."—*Ex.*

GLYCEROLE OF CELERY COMPOUND.—This safe mixture (containing no opium) for the relief of infants teething and for adults suffering from nervousness, headache, etc., supplies a want long felt by the profession, and should meet with their hearty support, as its advantages over the strong narcotics will be at once apparent to every physician. *Celery Compound* has been thoroughly tested and approved by the head nurse at the 'Toronto Infants' Home and Infirmary, and strongly recommended by her.