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THE

MONTREAL MEDICAL JOURNAL.

VOL. XXIV. NOVEMBER, 1895. No. 5.

Original Address.

INTRODUCTORY ADDRESS

DELIVERED AT THE OPENING OF THE SIXTY-THIRD SESSION OF THE MEDICAL FACULTY OF McGILL UNIVERSITY OCTOBER 1ST, 1895.

By F. G. FINLEY, M.D., Lon.

Physician to the Montreal General Hospital, Assistant Professor of Medicine and Clinical Medicine, McGill University.

GENTLEMEN,

We meet to-day to inaugurate our Sixty-third Session. It has been customary for many years past to precede the regular work of the session by an opening lecture, and this year it has fallen to my lot to perform this task.

My first duty is the pleasing one of extending to you on behalf of the Faculty a hearty welcome as students in the Faculty of Medicine. The pleasure of my task has been, however, somewhat alloyed by the diffidence I feel in speaking to you on an occasion which marks such an important epoch in the lives of many of you, that of a start in what is to be your real work in life. My only encouragement has been that it is not many years since I trod the same path that you are now entering, so that I can appreciate and sympathise with your difficulties, and that possibly something I may say will strike a sympathetic chord and be of use to you in your journey.

This occasion is in one respect destined to be a memorable one in the history of our Faculty, as it is the first public opportunity we have had of welcoming our new Principal, Dr. Peterson. Dr. Peterson's reputation as a scholar and administrator has preceded him, and we trust his presence may mark a new epoch in the prosperity and welfare of the University over which he has been chosen to preside. I feel I only voice your sentiments in extending to him a cordial greeting, and in assuring him that he will have the hearty sympathy

and co-operation of both teachers and students of this Faculty in all measures connected with the interests of the University.

To all of you who are here for the first time, this occasion takes the place of an introduction and gives us an opportunity to congratulate you on your choice of the profession of medicine. Although not one in which wealth is often attained, yet you will find that its pursuit is attended by an ever increasing interest and enjoyment. Taxing, as it often will, your physical and mental qualities to the utmost, yet there is the corresponding reward in the constant satisfaction and pleasure of alleviating distress among your fellow-men.

You are further to be congratulated on entering on the study of medicine at this late period of the century when so many of the difficulties experienced by your predecsssors have been smoothed away. I will not now enlarge on the great advances made in medical knowledge during the past quarter of a century, but if there is more to learn, I believe that the work is more systematised, that the facilities for learning are vastly improved, and that the change in methods of teaching by substituting the demonstration for the lecture render the task a pleasure rather than a labour. The only point you can regret is that you were not born a little later, when the advance in medical knowledge will compel a lengthening of the course to five or six years instead of the present four.

During the next few months you will doubtless hear much of heredity and environment in shaping the destinies of man. In the latter you will, I believe, find here much to stimulate your best energies, and it remains with you to take every possible advantage of the surroundings in which you are placed. The old tradition of frittering away the first and third years on unworthy trivialities, a tradition which is not yet extinct in all medical schools, has long become relegated to ancient history as far as this college is concerned.

Hitherto your training has been chiefly in literary subjects, and your method of learning altmost altogether from books. You are now called upon to acquire knowledge not only from books, but from the book of nature. You must learn to

"Find tongues in trees, books in the running brooks, sermons in stones."

The faculty of observation must be brought into play, and one of the chief ends of your work here is to acquire this habit in association with your work. This quality is one which can be successfully cultivated by any one willing to devote the time and labour necessary for its acquisition. You will soon find that opportunities are given you to verify the statements made by your text-books, and just in propor-

tion as you devote your energies to doing so will you become good observers.

No sane individual would attempt to read through Quain or Grey and then assert that he had a knowlege of anatomy. Unless accompanied by practical work, such labour would be completely thrown away. The dissections performed, a clear mental picture must be carried away of the relative position of artery, muscle and nerve, and with the aid of a text-book important features are impressed so that the eye and the memory work in harmony. This process of reading and observing must be repeated again and again until the structures become as familiar as the landmarks of your native town. This method is no doubt tedious, but I can assure you that if followed out it will result in a knowledge of the subject which can readily be recalled in later years, and as an immediate result it will enable you to face the ordeal of the primary examination with the assurance of a veteran regiment going into action.

In such subjects as physiology and chemistry you will be greatly assisted in obtaining a real grasp of your subject by the laboratory work, and by the experiments performed to illustrate the subject. Here again I would impress on you the importance of carefully going over the steps of the experiments, and of thoroughly comprehending the deductions made from them.

Whilst a thorough knowledge of facts is the essential basis of a medical education, it is necessary that they should be arranged in an orderly fashion. Each fact, so to speak, should be pigeon-holed and not mixed up promiscuously like the contents of a carpet bag. A proper arrangement and use of your knowledge can only be obtained by the cementing process of thought. It is not sufficient to know the facts, but their relation to each other, and to their bearing on other subjects, must all form a matter of much reflection and no little mental labour.

It is, perhaps, a criticism that may be made on the present system of medical education that the student is not taught to think, that the struggle for facts is so keen that the time for thought is thereby curtailed. I am inclined to think that there is much truth in such statements. There is a tendency to add various subjects to the curriculum, either under the pretence of utility or of broadening the presumably ever elastic mind of the over-worked student, whilst there is no corresponding extension of the period of study. We can hardly be accused of not providing sufficient straw, but we are perhaps a little unreasonable in the demand for bricks. This difficulty to which I have referred has been met fairly by the somewhat radical

change adopted by this Faculty of adding nine months to the length of the curriculum. By this step ample time should now be secured for reflection and the work should be of a higher and deeper quality than before.

On entering on the study of disease you have the advantage of a special preparation in the primary branches. Anatomy has given you an insight into the structure of the body, and has given you the opportunity to observe and verify statements for yourselves. Physiology and chemistry, in addition to teaching you much that has a direct bearing on the final work, has also helped to cultivate your reasoning power and introduced you to the methods adopted in scientific argument.

Entering on your final work time need not be lost in acquiring the methods of study, and the usual experience of the senior student, of the comparative ease with which the final branches are mastered, is in large measure due to the careful drilling in the primaries. The principles to be followed are a repetition of the habit of careful observation, thoughtful habit, and, I may add, hard work.

In the short space of two years it is not to be expected that more than the important elements of the knowledge of disease can be mastered. Much remains to be learned after college days are over, and it is thus of even more importance to lay plans for future extension than to rear a showy but flimsy structure at the outset. When we find the most distinguished members of the profession admitting, towards the end of a life of close and constant application, that they have still much to learn, it is obvious that the student can only obtain the rudiments of this education during his college career. This principle I feel is so important that with your permission I would like to apply it to one of the great final branches—that of medicine—and enquire for a few moments how the brief period of two years allotted to its study can best be spent.

To an audience of medical students I need not dwell on the importance of the subject. For the great majority of medical men medical cases form the bulk of every-day work, and it is therefore important that they should be well prepared to deal with them. Even for the specialist it is important to be accurately acquainted with the abnormal workings of the body in order to avoid the too common error of regarding every derangement of function as a special manifestation of disease in his own limited field of labour.

Of late years there has been a tendency to look down on didactic lectures as being superfluous in the presence of the numerous and excellent text-books in almost all departments of medical literature.

Lectures were started in the pre-text-book days, when they opened up channels almost inaccessible to the student. I feel convinced, however, that the lecture has not yet outlived its day. The appeal to the ear, and the personal influence of a lecturer are, I believe, of very great service in impressing the subject on the memory. A judicious course of lectures in which broad principles as well as important details are treated are of very great help to most students. There is the further advantage of mapping out a course of work, of noticing the more recent advances in medical science, and of emphasizing the important features of the subject. It is, however, a great mistake to trust entirely to note-taking, a habit which I fear is still too prevalent in this school. The man who is anxious to take down every word becomes for the time a mere machine, and fails to profit to the same extent as if he paid more attention to the thoughts and not to the mere sequence of words of the lecturer.

A good text-book should be selected and the subject of the day's lecture carefully studied when it is still fresh in the mind. A single book on each subject is quite enough, and the attempt sometimes made to read two or three authors, although at times useful in elucidating a doubtful point, can as a rule only result in confusion.

It is, however, in the hospital that a real knowledge of disease must be acquired, and it is here that the habits of observation and of reasoning acquired by the training in the primary branches are of the greatest service. The first few months of hospital training are occupied by attendance on clinical demonstrations, by clinical chemistry and bacteriology, and by training the senses in the various methods of physical examination, and it is only when this probationary period is passed that the full benefit of hospital work can be obtained. Clinical demonstrations are then still in order, but the stage of spoon-feeding must now in part give way to individual effort on the part of the student, and he must depend to a large extent on his own efforts, if he is to obtain any real insight into his subject.

It obviously impossible for any clinical teacher to deal with his subject in anything like a complete manner. He cannot impart all his own difficulties and failures, his successes and experience, and at best he must leave out much which he would wish to impart. The student must complete the teacher's work by following up cases for himself, by observing their course, and so gradually gaining an experience of his own.

Of all departments of clinical work in which this self-training can go on, the most valuable is to be obtained by the thorough study of individual cases by means of accurate case-taking. It is exceptional

to find, apart from a very few, that this work is appreciated, and the chief object of many seems to be to escape with the minimum amount of labour. The advantages of this work are so obvious that I would hardly stop to consider them had I not learned by experience how often they are neglected. In the first place the art of case-taking is one which requires very considerable practice, and it is easy to pick out an ill-trained man by the manner in which his cases are reported. Systematic training and constant practice in this art would, I believe, exercise a most healthy influence on the medical literature of our day; and the vast quantity of unimportant or irrelevant matter which fills many of our journals would thereby be greatly curtailed and an inestimable boon conferred on the medical public. The habit of recording your observations accurately not only teaches you to observe carefully, but is a training of no mean value in exercising your powers of description. Accuracy in description is by no means easy, as any of you may convince yourselves by trying, for example, to describe a skin eruption in such a way that it conveys a clear picture to another. You will find that every case you report will open up fresh channels of thought and by leading you to compare and classify your facts will prove a stimulus to thinking out the various difficult problems arising in any department of serious work. The knowledge of human nature attained by the study of hospital cases is again another accomplishment which will often prove of quite as much value as technical medical knowledge.

So strongly is the need of this individual work felt by the Faculty, that this year it has been decided to reduce the number of clinics in order to leave leisure for it to be done. It is not meant that this leisure should be frittered away in lounging around the wards and enjoying the side shows and curiosities, but in careful earnest work at the bedside and in the clinical laboratories. The old method of walking the hospitals, much as one might promenade on a popular thoroughfare, will not prove of much use in becoming familiar with the features of disease. The free and easy customs attributed to those jovial creations of Dickens, Benjamin Allan and Bob Sawyer, no longer linger among us, and I fear that the natural selection exercised by examining bodies has caused this species to become almost extinct.

In the study of disease it is well as a student to obtain as large and varied an experience as possible, but thoroughness should never be sacrificed for quantity. It is far more important to see a few cases well and know everything about them, than to rush through a larger number in a careless and haphazard fashion. Cases thoroughly mas-

tered in student days will stand out as types, and in after years these early impressions will be the ones which are most vivid at critical moments, and memories of them will be prized when you are thrown upon your own resources.

A great number of graduates take away with them a stack of note-books " full of wise saws and modern instances," but how many carry a book containing a summary of their own clinical experience ? Such a book, if carefully compiled from daily observation, will prove a volume of inestimable value. Memory is often a rather treacherous friend, but it is surprising how a little aid such as I have mentioned will bring back a sharp, clear picture of long dormant facts.

That the chief object of a medical education is to turn out good doctors goes without saying, but in addition to the special knowledge acquired, there is also the advantage to be gained by the mental culture obtainable by a clear habit of thought, and that higher education which fits a man not only to assume the duties of his profession, but also places him in a position to observe and pass judgment on the manifold interests of human life.

The mere study of medicine from books yields indeed a barren harvest, but if the mental faculties are cultivated as they may be by a medical training, not only will the success of the physician be increased, but his enjoyment of life will be multiplied manifold.

Original Communications.

THE OPERATIVE TREATMENT OF MOVABLE KIDNEY.*

By James Bell, M.D.

Surgeon to the Royal Victoria Hospital and Consulting Surgeon to the Montreal General Hospital; Professor of Clinical Surgery, McGill University.

A tendency has recently been shown in our profession to sneer at and ridicule the operative treatment of movable kidney—to assert that it is useless, unnecessary, experimental, etc., and, in short, to assume that on account of its simplicity and freedom from danger it is a favourite operation with the unscrupulous and that it is frequently, if not generally, unnecessarily performed.

Now, I would not assert that there is no ground for such belief (although I have no personal knowledge of it), nor would I ask you to believe that every case of movable kidney requires operation; far from it; but in this respect this operation does not differ from many other operative procedures, such, for instance, as those for relief of stone in the kidney, stone or stones in the gall-bladder, bow-legs and many other deformities. It is not necessary to say to the members of this Association that in none of these conditions does the surgeon operate simply because of the existence of such a condition, but because of the symptoms which it produces, and which can, it is thought, with at least a fair degree of probability be remedied by operation. Who has not seen, for example, in the autopsy room, renal and biliary calculi which had not been known to have produced symptoms during life? And again, who is there who is not acquainted with men and women who are living happy and useful lives, in spite of various kinds and degrees of deformity? So, too, a movable kidney which gives rise to no symptoms requires no treatment, and I do not doubt but that the discovery of this condition to the patient's knowledge is often one of the greatest misfortunes to her or to him, and is frequently the cause of a train of subjective symptoms which will probably never be entirely removed by operative or any other treatment. My own personal views upon this subject may be expressed in the following statements:

1. That preternatural mobility of the kidney often produces, *per se*,

* Read by title at the meeting of the Canadian Medical Association in Kingston, August, 1895.

many very troublesome symptoms which are quite frequently sufficient to incapacitate the patient.

2. That such undue mobility often leads to organic changes in the organ.

3. That fixation of the kidney under these circumstances is the only rational treatment.

4. That in the great majority of cases (which require treatment), this can only be done by operative measures. (I cannot conceive that it is possible to fix the kidney by any kind of belt, or truss, or appliance, without producing injurious pressure upon the intra-abdominal organs, and, as a matter of fact, I have been unable to satisfy myself that it is possible to retain a movable kidney in its proper position by any kind of appliance, even at the expense of injurious pressure upon other organs).

5. That a carefully performed nephrorrhaphy should practically always succeed in permanently fixing the organ.

6. That nephrectomy for undue mobility of the kidney can hardly ever be necessary.

In illustration of the above statements I propose to give very brief reports of five cases upon which I have recently operated for this condition.

CASE I. Mary G., æt. 26. Farmer's wife. Had been married seven years and had had four children, the eldest 6 years of age and the youngest 7 months.

This patient came to hospital complaining of painful and frequent micturition and pain in the abdomen on walking. She was a native of Canada, had had the usual diseases of childhood and an attack of acute rheumatism a year and a half before admission. Since the attack of rheumatism, she had suffered from palpitation and other cardiac symptoms, and examination discovered a loud apex systolic murmur (mitral regurgitant). There was no tubercular history. The present illness began 16 months before admission, when the symptoms above detailed were first noticed, and about the same time she discovered a freely movable mass in the right side of the abdomen. From this time she was quite unable to do her ordinary household work. Her symptoms were attributed to uterine disease, and she was sent to a gynæcologist (Dr. Wm. Gardner), whose examination discovered only a thickened tender ureter on the right side. She was transferred to my ward in the Montreal General Hospital on the 20th of October, 1892, when the following conditions were noted: The right kidney was greatly enlarged (two or three times its normal size), very freely movable and tender on manipulation. Movement of the

body from side to side, or rising to the erect posture caused a sudden dragging pain. While lying in bed the pain and frequency of micturition were much diminished. The right ureter could be felt through the anterior vaginal wall as a hard cord, as large as a large lead pencil, and tender on pressure. The urine was normal in quantity, cloudy, contained mucus and a small amount of pus. There was a little albumen (due to the pus), but no sugar. Tuberculosis was suspected, but several careful examinations failed to discover any trace of tubercle bacilli. On the 24th of November, 1892, the patient was etherized, the urethra dilated and the ureters catheterized by Kelly's instrument. The result was most satisfactory. Cloudy, turbid urine flowed from the right ureter and perfectly clear urine from the left. The ureteral orifices could be felt with the finger in the bladder, and catheterization was not in the least difficult. There was no evidence of disease in the bladder itself.

On the 29th of December the kidney was fixed to the loin by three sutures of silk worm gut, through the usual oblique lumbar incision. (These sutures included capsule and kidney tissue). The kidney was found to be uniformly enlarged, with the pelvis considerably dilated, and the ureter enlarged and thickened at the renal as well as at the vesical extremity. This patient made an uneventful recovery, but on account of the inflammatory condition of the kidney and ureter she was kept in bed until the 9th of February, 1893 (40 days), when she was sent home. By this time the symptoms had almost entirely disappeared and the kidney and ureter had greatly diminished in size. She suffered, however, from incontinence of urine from the dilation of the urethra. I have not seen this patient since she left the hospital as she lives in a remote country district, but I have heard from her several times, directly as well as indirectly, through neighbours. She and they assure me that she is perfectly well and has done her own house work ever since her return from the hospital. Her only complaint is that there is still a tendency to incontinence of urine, noticed when coughing, etc. The net result, therefore is, in this case, that a young healthy woman, who had been confined to her bed and unable to do anything about her house for sixteen months previous to operation (although she had borne a child in the meantime), and whose movable kidney and its ureter were well on the way to inflammatory disorganization (pyonephrosis), has been, since the operation (now two years and nine months), in what she describes as perfect health. I am, of course, unable to report upon the condition of the kidney and ureter, but I am assured that the urine is "quite clear." However we may attempt to explain it, I think there can be little doubt but

that the pathological conditions in the kidney and ureter at the time of operation began with and were primarily due to the preternatural mobility of the organ.

CASE II. D. C. F., æt. 40, merchant. A tall, spare man with marked tubercular history, complained of soreness in the right side and back when walking and pain in the right side of the abdomen. He had had right-sided pleurisy twenty years before coming under my observation and had been under treatment for ten years for the above-mentioned symptoms. He had also suffered during this period with an oppressive feeling in the stomach and occasional diarrhœa. He had been treated for dyspepsia, disordered liver function and gall-stones. He had also been severely dieted and had taken much medicine. For a year before admission to the Royal Victoria Hospital (April 29, 1895), where I operated, he had lived entirely on milk and soda biscuits and had lost much weight. He had also been unable during the greater part of the year to do any work. There had been no definite urinary symptoms and the heart and lungs were normal. A movable tumour had been discovered in the right side about twelve months before admission, but a definite diagnosis had not been made until six months later. When he came under my care the diagnosis was quite clear. The right kidney, apparently twice its normal size, moved freely into the epigastrium and down into the pelvis. The urine was clear and normal in every respect. Operation was performed in the usual way on the 1st of May, 1895, and an unusual condition of the kidney was discovered. The pelvis of the kidney extended through to the convexity of the organ, so that there were two masses of kidney tissue representing its extremities connected by a fibrous sac containing an ounce or two of urine. The urine was evacuated through a needle puncture on the posterior surface, the ends approximated and each attached by a silk-worm gut suture (passing through fibrous capsule and kidney tissue for about three-quarters of an inch) to the end of the lumbar incision (fascia and muscle). The patient made an uninterrupted recovery and was discharged from hospital on the 23rd of May. I saw him again on the 16th of July, when he was quite well. The kidney could not be moved from its position in the loin and he had gained much in weight. His only complaint was of an area of disordered sensation in the skin of the abdomen—doubtless due to section of, or possibly only a traumatic neuritis of, the ilio-hypogastric nerve.

CASE III. Mrs. L., æt. 52, a spare woman, the mother of eleven children, was admitted to the Royal Victoria Hospital on the 4th of May, 1895, with right pyonephrosis and great mobility of the kidney. She

had been married thirty years and had had two miscarriages in addition to the eleven children above mentioned. She had suffered with the right side for twenty-three years, especially on quick movement or in lifting, and she attributed this trouble to a fall down stairs, in which she had struck upon a barrel. Four years before admission she first felt a swelling in the right side of the abdomen. Since that time she had suffered a great deal with pain and tenderness in the right side and painful and frequent micturition. During sixteen days of observation in hospital prior to operation the amount of urine secreted varied from 18 to 34 ounces daily and it contained a large and variable amount of pus. On the 25th of May, 1895, the kidney was exposed by the usual oblique lumbar incision and was with some difficulty brought into the wound. Two large abscesses were evacuated on the posterior surface of the organ and a rough, irregular stone about the size of a filbert was removed from the trumpet-shaped orifice of the ureter, where it lay quite free and movable. On account of the disorganized condition of the kidney I was strongly tempted to remove it, but as it contained at least 25 per cent. of apparently normal secreting structure, and as I had no knowledge of the condition of the other kidney, I decided to fix it by suture to the edges of the lumbar wound. A drainage tube was inserted, but it came out in forty-eight hours and was not re-inserted. This patient made excellent progress for eleven days, when she developed a left lobar pneumonia. In the meantime the wound had become quite healed and the kidney seemed to be of almost normal size. On the 23rd of June, thirty-four days after operation, the kidney again became swollen and painful, and on the 25th of June the original incision in the loin was reopened and the kidney was found to be firmly adherent to the parietes. It was reopened and a large quantity of pus escaped. A drainage tube was kept in the wound for three weeks. There was no escape of urine and the wound healed immediately when the tube was removed. This patient is still in hospital and has had at times ever since the original operation sharp attacks of pain about the vesical extremity of the ureter. It is of course open to question whether a nephrectomy would not have been a better operation in this case, but I quote it to show that the kidney can be very safely and certainly fixed by two or three sutures of silk-worm gut passed through the kidney structure as well as the capsule. In this case it is impossible to say whether the symptoms were not all due from first to last to the calculus, but it is at least debatable whether the earlier symptoms were not due to repeated obstructive conditions caused by twisting of the ureter and the stone formation secondary to this condition, or perhaps only a

coincidence. Certainly I do not think that the mobility of the kidney can be attributed to the stone.

CASE IV. Mrs. B., æt. 41, stoutly built and well nourished, the mother of eight children, was admitted to the surgical wards of the Royal Victoria Hospital, from the gynæcological side, on the 24th of May, 1895, complaining of pain in the right side and back, and of attacks of frequent micturition. She had been an invalid for five years on account of the above symptoms, which were always aggravated by exertion, and which had been growing steadily more severe. She was otherwise in perfect health and the urine was quite normal. The right kidney could be felt of normal size and painless on pressure, through the lax abdominal wall, and was freely movable down to the brim of the pelvis and over to, or beyond the middle line of the abdomen. On the 27th May it was fixed to the loin by three silk worm gut sutures, introduced into the kidney tissue, through the ordinary oblique lumbar incision. She made an uneventful recovery and was discharged on the 15th of July, feeling quite well and with the kidney not discoverable by palpation. Her stay in hospital was somewhat prolonged by a little suppuration at the posterior angle of the lumbar wound. On the 15th August, her physician, Dr. Pagé, gave me a most favorable account of her condition.

CASE V. Lucy H., æt. 19, was first seen in consultation in February, 1894. She was a highly neurotic girl, and although the prominent symptoms were pain in the back and pelvis, and attacks of suppression of urine, I declined to operate. In fact, up to the time of my visit, the symptoms had been attributed to a pelvic lesion, and the diagnosis of movable kidney and its possible causative relation to the symptoms (or to part of them), was then first made. Her attention having been directed to the movable condition of the kidney, all the local symptoms became greatly aggravated, and she was sent to me again in March, 1895, for operation. I again advised against operation on the ground, that on account of the neurotic condition of the patient, it was impossible to determine what symptoms, or if any of the symptoms, were due to the excessive mobility of the kidney. Her physicians were greatly disappointed at my decision and strongly urged operation, so that after a good deal of correspondence on the subject, I went to her home in the State of New York and operated in the usual way (using four silk worm gut sutures), on the 22nd of May, 1895. I have not seen this patient since the day I operated, but I have heard repeatedly from her physicians, the substance of the reports being that the lumbar wound suppurated and healed slowly, but that the kidney remained fixed in its normal position.

It is not my intention to discuss the subject of movable kidney in its entirety, nor, considering the recent literature of this subject, would I be justified in doing so, even if time permitted. The whole history of the surgical treatment of this condition (and therefore, practically of its recognition as a condition requiring such treatment), is to be found in the surgical literature of the last fifteen years (since Prof. E. Hahn, of Berlin, described the operation of nephrorrhaphy in 1880). In 1890, two very complete and exhaustive papers were published, independently, by two of the leading American surgeons, one in *The Annals of Surgery* (Vol. 2, 1890, page 81), by Prof. W. W. Keen, of Philadelphia, the other by Dr. A. J. McCosh, of New York, in *The New Medical Journal* (Vol. 1, 1890, page 281). In both of these papers the subject is systematically discussed, and a complete list of all operations which had been reported up to the date of publication, is carefully analyzed. To quote from Dr. Keen's list of 134 operations which he had tabulated to August, 1890, there were 4 deaths, 4 failures, 28 cases improved, 9 unimproved, and 66 cured—besides a few cases described as satisfactory, "possible cures," etc.—not a bad showing for the first decade in the history of a new operation! Since that date, August, 1890, the operative treatment of movable kidney has continued to grow in favour with surgeons, and has given, from year to year, increasingly good results. C. Neumann, of Berlin, in the *Centralblatt für Chirurgie*, (No. 21, 1894,) has collected 283 cases of nephrorrhapy with the following results: 65.32 per cent. cures, 10·36 per cent. improved, 22.07 per cent. failures and 1.81 per cent. fatal. Amongst the prominent advocates of the operation during the last five years may be mentioned Franks, Küster, Tuffier, Guyon, Guermonprez, Salzer, Zatti, Le Cuziat and many other European and American surgeons.

I shall not attempt to discuss the questions of causation, diagnosis, influence of sex, age or occupation, nor even the selection of cases for operation, except to say, that whenever the symptoms are sufficiently distressing to cause invalidism, operation should be recommended. In this connection, I wish to emphasize the statement already made that excessive mobility of the kidney when of long duration, in at least a certain number of cases (probably much larger than has hitherto been suspected), leads to destructive changes in the organ. (See Cases I., II. and III.) As to the operation itself, the kidney is exposed in the loin, preferably by an oblique incision extending downwards and forwards from the outer border of the erector spinæ muscle parallel to the twelfth rib and a finger's breadth below it (Treves' operative surgery). In the earlier operations the fatty capsule was sutured to the

parietes and there were many relapses. The next step was to separate the fatty capsule from the kidney and pass the sutures through the fibrous capsule, but it was soon discovered that the capsule stripped off very readily. Then advancing a step further the suture was passed into the kidney tissue, including both parenchyma and capsule. Experience soon showed that no apparent injury was done to the kidney and a much more secure approximation was effected which gave better permanent results. Other methods employed have been to abrade the fibrous capsule or to partially remove it in order to approximate a raw surface to the transversalis fascia; to pass the suture around the last rib or through its periosteum, etc. Generally speaking, however, the method employed at the present day is to pass three to four or five sutures through the fibrous capsule and kidney tissue for the space of three-quarters of an inch in length and a quarter of an inch to half an inch in depth and attach them to the cut edges of the transversalis fascia and oblique muscles. There is probably no better arrangement of the sutures possible than that recommended by Mr. Morris—to pass a suture from each edge of the wound near the convex border of the kidney (including muscle, fascia, capsule and kidney tissue) and a third nearer to the hilum, this latter to include both edges of the wound as well as capsule and kidney tissue For suture material catgut has been pretty generally abandoned. Silk is open to the same objection in this as in other operations—that is, that occasionally a sinus forms and persists until the suture is removed. Animal tendon has been employed, and silk-worm gut has of late been used perhaps more frequently than any other material. It seems to be free from objection and answers every purpose. In the *Revue Médicale*, No. 6, June, 1895, is described a new operation for the fixation of floating kidney by Vulliet and Poullet. It is described as fixation by living tendon and consists in suture through the capsule by a detached tendon of the dorsalis longus muscle. (I can only say of this procedure that it seems to me at first sight to be an unnecessarily complicated one.) It is probably better in most cases to allow the wound in the parietes to heal by granulation, both to avoid the risk of cellulitis and to secure a firmer adhesion in the line of the wound. This does not involve any considerable delay in healing, as the wound contracts and closes with amazing rapidity. The anatomical distinction between floating kidney, which is surrounded by peritoneum, has a distinct mesonephron and is congenital; and movable kidney, which is retroperitoneal, has no mesonephron and is generally acquired, is of no practical importance surgically and probably could rarely, if ever, be made out during the performance of an ordinary operation for fixation of the kidney.

RESULTS OF GASTRO-ENTEROSTOMY.*

By Robt. C. Kirkpatrick, M.D.

Demonstrator of Surgery, McGill University. Surgeon to the Montreal General Hospital.

Mme. M. came under my care on October 12, 1894, complaining of "indigestion." This had been going on for some years. For several months she had been getting thinner and weaker, while for a month past she had been suffering from pain in the region of the stomach coming on after the ingestion of food, and from vomiting, usually of the substance of her meals and but rarely of a "coffee-ground" character. Examination of the abdomen revealed a small indistinct mass in the epigastric region to the left of the middle line.

She was admitted into the Montreal General Hospital and a test breakfast given with the following results: The amount of fluid expressed from the stomach one hour after taking a cup of tea and two ounces of bread was much increased, being more than one pint, and was composed of mucus and undigested food, with very apparent quantities of butyric and lactic acids; hydrochloric acid and pepsin were absent.

She was kept in the hospital for six weeks and the effect of dieting and lavage was absolutely *nil*, while the tumour became larger and more apparent until it appeared to be about the size of a hen's egg. It was not movable to any extent, and inflation of the stomach did not cause it to move to the right of the middle line. Such being the case, it was decided to make an exploratory incision and then either remove the growth or perform a gastro-jejunostomy, as circumstances seemed to warrant. Accordingly, on December 6th, the patient being duly prepared and etherized, an incision was made in the middle line extending from the ensiform cartilage to the umbilicus. It was then seen that the pylorus was involved in a growth which extended thence along the lesser curvature nearly to the cardiac orifice. A longitudinal incision was made through the pylorus in order to examine the growth, and there was found a fibrous mass presenting all the characteristics of a carcinoma, a diagnosis which was afterwards verified by microscopic examination of a small portion removed. Hæmorrhage was free from the cut surface, requiring the application of the thermo-cautery to check it. The growth was too large to remove with any hope of success, so the pyloric incision was closed by

* Read by title at Canadian Medical Association, Kingston, August, 1895.

sutures of silk, and at one place where it was difficult to secure apposition of the serous surfaces a graft of omentum was attached and held in place with a few silk sutures. Gastro-jejunostomy was done, an opening about four inches in length being made and the stomach and bowel being attached one to the other by a double row of continuous silk sutures. The abdomen was then closed. The recovery was uneventful and the patient left the hospital on December 31st, twenty-five days after the operation.

On March 16, 1895, the patient returned for examination. Since leaving the hospital she has been gaining in weight and strength, now weighing 129 pounds, a gain of 12 pounds. Occasionally she has slight attacks of pain in the region of the stomach, but no vomiting. She is able to eat ordinary food and the bowels move regularly. She is able to do her housework without undue fatigue. The tumour is a little larger, but is not growing as rapidly as it did before the operation. The test breakfast gave the following result: The quantity of fluid was eight ounces, principally mucus. For her supper the night before she had taken a chop and there was no evidence of this in the fluid expressed. Hydrochloric acid was absent, as was also the pepsin and its zymogen. The curdling ferment was present, but seemed very inactive. Butyric, lactic, and acetic acids were not present in any appreciable quantity.

The stomach contents were examined again on July 17th with practically the same result, except that the quantity of fluid was only two and one-half ounces.

Such is the history of the case given very briefly, and the result is, I think, worthy of some consideration. We have a patient suffering from an incurable disease, and that disease is advanced to such a degree that she is not able to continue her daily work. The question is what we shall do for her. If left alone she will die a painful and lingering death. We have no drug that will produce any effect on the cancer; our sole resort is therefore in operation. If not successful we only anticipate the fatal result by a short time, while if we succeed we give her an increased lease of life and usefulness. In this case the growth was too large to remove, so the only resource was to make a new opening between the stomach and the bowel. And what is the result? In three and a half weeks the patient goes home, takes her place at the head of her household, and is practically well. The vomiting and constipation are relieved, the pain is lessened until it scarcely incommodes her at all, and she is able to eat whatever is set before her. The examination of the stomach contents show that while the motor functions of the stomach are restored and the hyper-

secretion lessened, its digestive functions are not improved. Still the fermentation is prevented by passing the food on quickly and the stomach is able to empty itself more and more completely, as shown by the lessened quantity of fluid obtained at each test. Besides, the growth of the tumour is much slower, probably on account of the lessened irritation when the fermentation is done away with.

The following extract from the "Epitome of Current Literature" in the *British Medical Journal* for January 5, 1895, is of interest because it bears out our observations.

"Rosenheim, of Senator's clinic (*Berl. klin. Woch.*, December 10th, 1894), has examined ten cases, and has nearly always found, whether the primary disease was malignant or not, delay in the passing on of the stomach contents. In a patient with pyloric carcinoma, upon whom Hahn did a gastro-jejunostomy four months previously, there was increase in weight and much improvement, but the secretory functions of the stomach diminished. Bread, meat, and especially vegetables were retained longer than usual, but in this respect improvement appeared to be taking place. The bowels acted satisfactorily. The tumour did not appear to have increased, and the author thinks that the operation tends to delay such growth. It had certainly done away with the retention of fluid in the stomach. In another case in which gastro-jejunostomy was done for carcinoma by Hahn nine months ago, the woman was so much improved that she became pregnant; abortion had to be induced. The patient was without stomach symptoms. The secretory powers were *nil*, but the motor power showed improvement. Complete restitution of the stomach mechanism has not hitherto been observed, as Mintz's case is not quite free from objection. The author then records a case of pyloric obstruction due to the cicatrical contraction of an ulcer, and in which gastro-jejunostomy was also done by Hahn four months previously with the most satisfactory results. The fasting stomach was empty one hour and three-quarters after a test breakfast. The secretory and motor functions of the stomach were normal, and the patient had gained 52 pounds in weight. The gastric hypersecretion noted before the operation was, in the author's opinion, now cured. Here the abnormality in secretion was secondary. There are undoubtedly many cases in which it is primary and and the motor insufficiency secondary. The author contends that in such a case as the one above reported hypersecretion is no contra-indication to the operation."

Taking the results of Rosenheim's observations, together with the case reported, it is evident that in cases of carcinoma of the stomach where there is interference with the motor functions as evidenced by

dilatation of that organ with fermentation and vomiting, we should advise our patients to have a gastro-enterostomy performed, and we can promise them considerable improvement in their condition and an increased lease of life, and that at a minimum of risk.

I have purposely refrained from discussing the mode of operating and the relative merits of suture and of the Murphy button, because the point I wish to draw attention to is the result we may look for after the operation, and I do not wish to enter on any discussion which might lead us away from the main point.

LEGAL RELATIONS OF REASONING MANIA.

By Edward C. Mann, M.D., L.S.S., M.R.A.S.

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Psycho-sensory insanity, furnishes good ground for invalidating civil acts, for notwithstanding the apparent integrity of the intellectual powers, it is probable that their operation is influenced to a greater or less extent by a derangement of the moral power. We certainly ought not to judge the civil acts by the standard of sanity and attribute to them the same legal consequences as to those of sane men, because their real tendency is not and cannot be perceived by the reasoning maniac. These cases, like Guiteau and others of that stamp, always think that the end justifies the means, and in my examination of the insane I never met a single case of this kind, where fear of punishment would restrain them from criminal acts.

When a case of reasoning mania, and particularly that class of reasoning maniacs who may properly be regarded as having a monomania for homicide, commits a crime and the violence of the paroxysm abates, the insane man generally delivers himself up and makes no effort to escape. Sometimes, undoubtedly, the person flies from the scene and tries to escape, but most authorities on insanity unite in thinking this exceptional.

In homicidal insanity, the criminal act for which its subject is called to account, is the result of a strong, and perhaps sudden, impulse, opposed to his natural habit, and is generally preceded or followed by some derangement of the healthy actions of the brain or other organ.

Taylor (643 *Med. Jour.*) relates the case of a young man who entered a shooting gallery, took up a pistol and deliberately shot and killed the proprietor. He said he had no knowledge of the person; he shot him simply to be hanged for it. He had been thinking of suicide for some years.

In most cases, we regret to say, perversion of the feelings, the result of brain disease, unaccompanied with delusions, has not been held as sufficient ground to invalidate and nullify the acts of one so affected. The case of Guiteau is the last celebrated case of reasoning mania executed for murder, and we wish it might be the last spectacle of the kind in this country.

In the trial of Abner Rogers for murder, Chief Justice Shaw, of

Massachusetts, said : "If then it be proved, to the satisfaction of the jury, that the mind of the accused was in a diseased and unsound state, the question will be, whether the disease existed to so high a degree that, for the time being, it overwhelmed the reason, conscience and judgment, and whether the prisoner, in committing the homicide, acted from an irresistible, uncontrollable influence. If so, then the act was not the act of a voluntary agent, but the involuntary act of the body, without the concurrence of a mind directing it." (*Trial of Abner Rogers.* By Bigelow and Bevins, 277.)

Wharton & Stillè (*Unsoundness of Mind,* 43), say that in 1846 Chief Justice Gibson, of Pennsylvania, said in a case he was trying: "There is a moral or homicidal insanity consisting of an irresistible inclination to kill or to commit some other particular offence. There may be an unseen ligament pressing on the mind, drawing it to consequences which it sees but cannot avoid, and placing it under a coercion which, while its results are perceived, it is incapable of resisting. The doctrine which acknowledges this mania is dangerous in its relations, and cannot be recognized except in the clearest cases. It ought to be shown to have been habitual, or at least to have evinced itself in more than a single instance."

Chief Justice Sims, of the same State, said : "Where its existence is fully established, this species of insanity (moral) relieves from accountability to human laws." (*Idem,* 44.)

Judge Edwards said in the Klein case, "It must be borne in mind that the moral as well as the intellectual faculties may be so disordered by the disease as to deprive the mind of its controlling and directing power." (*Select Cases,* 13.)

Judge Whiting, in the Freeman case (*Trial of Freeman, 1847, pamphlet*), expressed the same idea. In another case (*Com.* v. *Haskell,* 2 Brewster, 49) the Court said, "The true test of responsibility lies in the word 'power.' Has the defendant the power to distinguish right from wrong, and the power to adhere to the right and to avoid the wrong?"

The cases of Dean, Howson, Papavoine, Cornier and others, to be found on pp. 794-796 *Woodman & Tidy's Forensic Medicine and Toxicology,* are all cases of pure homicidal mania associated with reasoning.

It has been truly said that homicidal insanity has the following characters and the lawyer and jurist can easily discover them with the aid of one skilled in psychiatry. The homicidal acts of insane persons have generally been preceded by other striking peculiarities

of action, noted in the conduct of these individuals, often by a total change in character.

They have often been discovered to have either committed suicide, or to have expressed a wish for death, or to have even wished to be executed as criminals.

Their acts are motiveless, or in opposition to the known influences of all human motives. A man, known to be tenderly attached to them, murders his wife and children ; a mother detroys her infant ; or the victims are perfect strangers.

Their subsequent conduct is characteristic ; they seldom seek escape in flight ; they even deliver themselves up to justice, acknowledge their crime, describe their state of mind, or remain stupefied and overcome by the horrible consciousness of the atrocious nature of their deed.

The criminal murderer has generally accomplices in vice and crime ; there are assignated inducements to lead to the commission of the murder—motives of self-interest, of revenge, displaying premeditated wickedness. The acts of the madmen are in some instances of this character, but the premeditation is peculiar and characteristic. (P. 176, *Woodman & Tidy's Forensic Medicine.*)

Finally, insanity is a disease of the body, affecting the mind by deranging its faculties, causing such suspension or impairment of the healthy intellect, the emotions or the will, as to render an individual irresponsible.

The legal test of insanity in criminal cases should be the existence of any subjective morbid condition of the nervous system which misleads the mind or conduct. The basis of insanity consists in the changing and misleading subjective impressions of the insane person, coupled with the resultant change of conduct or of reasoning or both. This is a change of mental character as compared with former self or normal ancestral type. In insanity, physical disease, sickness, impresses itself on the conduct or charcter of the person affected by it, misleading and perverting him in the exercise of his psychic powers.

Clinical Reports.

REPORT UPON THREE CASES OF SYRINGOMYELIA.

By Ingersoll Olmsted, M.D.

It is by the kind permission of Professor Mendel that I am able to report the following cases of a disease which possesses considerable interest. The cases were brought before his class in Vienna during the last year.

Case I.—The patient, W. V., aged 32, a slightly built man, first came to the private poliklinik of Professor Mendel in January, 1890, when the following history was obtained:

Heredity and lues nil; healthy previous to 1875, when he had an ulcer on his arm and another on his lip, together with a carbuncle on his back. In 1880 he had dysentery, and in 1881 typhoid fever. In 1885 patient noticed that the ball of little finger of left hand was diminished in size and the finger was slightly brownish in colour. The hand became weaker and the muscles of the forearm smaller. Presently the other muscles of the hand became atrophic, and with this occurred a loss of the sense of pain, so that often and unwittingly he burned himself. In 1887 he had pain and pricking sensations in the middle and upper part of the back of his neck. In 1888 there was weakness of the muscles of right arm and hand and the sensation of this extremity became affected similarly to that of the left. Both hands became deformed. He had slight chills and a cold feeling in shoulders and arms. The voice changed somewhat, becoming harsh.

At the present time there is smallness of the cleft between the eyelids, the left being smaller than the right. Pupils small and unequal, left smaller than right. Action to light and accommodation prompt. Facial nerves intact.

There are several scars on the hands and arms, the result of former burns. The finger-nails are thickened, ridged and brittle (onychogryposis); the skin is smooth and glossy.

The left hand presents extensive atrophy of the muscles of the ball of the thumb and little finger, and of the interossei. The deformity known as "claw hand" is well marked. The patient has very little voluntary movement of the hand; it cannot be flexed on forearm, nor can the fingers be separated from one another. The pathological position can, however, be overcome by passive movement. The forearm muscles, together with the deltoid, pectorals and supraspinatus

of the left side are much atrophied. The right arm and hand are similarly affected, though in a lesser degree. The hand is flexed on the forearm and the fingers are extended, thus differing in position from the left. There is likewise atrophy of the deltoid, pectorals and supraspinatus of the right side, though not so advanced as on the other side. The muscles of neck and back also show atrophy. Fibrillary contractions are to be seen in the atrophied muscles, especially in those of the forearm and thumb. There is tremor of the hands, which is increased on voluntary movements. The power of grasping is much diminished, while that of flexion and extension of the forearm and arm is normal on both sides. The mechanical excitability of the muscles of the upper extremities is slightly increased. The biceps and triceps reflex on either side is absent. The examination of the lower extremities proved negative. The functions of the bladder and rectum are normal. Electrical examination showed incomplete reaction of degeneration in the atrophied muscles.

Sensory symptoms.—The surface of the body corresponding to both upper extremities and the trunk as far down as a line drawn around the body, commencing at the base of the zyphoid process, and passing on the right side to the seventh rib in the axilla and thence to the seventh dorsal vertebra behind, and on the left passing to the fifth rib and along this to the fifth dorsal vertebra, retain the sense of touch and muscular sense, while the perception of pain, heat and cold is very much diminished, and in the forearm and hands completely lost.

The right side of the face and a narrow zone around the body below the line above described, is hyperæsthetic to heat, cold, touch and pain. Below this is another band where pain, heat and cold are scarcely perceived. All the parts below this are in every way normal. The left side of the face is anæsthetic. Dermography is well marked on the upper portion of the trunk.

During the last five and a half years the condition of the patient has remained much the same, the atrophy being rather more advanced, and the deformity of hands more pronounced, although he has been free from pain. This latter point is important, for in pachymeningitis cervicalis hypertrophica the position of hand and atrophy is the same as in this case, but the excruciating pains in the back of the neck, shooting into the arms, with rigidity of the muscles of the neck, the more rapid progress of the disease and the absence of the characteristic sensory symptoms make an error in diagnosis almost impossible.

To recapitulate, the case presents then the following points:

1. Narrowness of the cleft between the eyelids. This depends on

paralysis of the sympathetic nerves coming from the cilio-spinal centre, which innervate the plain muscular fibres situated in the eyelids (Müller's muscle) and which regulate the size of the cleft. In Graves disease, on the other hand, these fibres are irritated, and as a result there is spasm of Müller's muscle and widening of the clefts.

3. Smallness and inequality of pupils, due to the same cause; the inequality being produced by the unequal involvement of the two sides of the spinal cord by the gliomatous tissue.

3, Anæsthesia of the left side of the face and hyperæsthesia of right side, due to the destruction of the ascending sensory root of the fifth nerve on the one side, with irritation of that of the opposite side. This root takes its origin in the cord, sometimes as low as fourth cervical nerve.

4. Atrophy of the muscles of hands, forearms, &c., attributable to involvement of the anterior horns.

5. Dissociate paralysis of sensation. With regard to the paths by which the different sensations are conveyed through the spinal cord to the brain, very little is positively known. The posterior columns probably convey that of touch and the muscular sense, while those of pain and temperature are supposed to course in the antero-lateral tract. The gliomatous tissue is thought to interrupt these latter nerve fibres when decussating in the cord.

CASE II.—A male aged 58, had mild attack of syphilis in 1869; no history of heredity. He enjoyed good health till August, 1894, when he felt some pain in the left arm and hand, followed by the feeling of numbness and pricking, especially in the ring and little fingers. The hand became slightly weaker.

At the present time we note narrowness of left palpebral fissure; left pupil smaller than right; reaction to light and accommodation good; blunted sensibility of left side of face to touch, pain and temperature; innervation of facial muscles normal. There is atrophy of the ball of the thumb and of the little finger, of the interossei, and of the flexors of left forearm. The nerve trunks are not painful to pressure. Touch and muscular sense in arm and hand appear normal, but there is absence of the sense of pain and of temperature. When a pin is stuck into the hand or forearm it is perceived simply as a sensation of touch unaccompanied by pain, so also when hot or cold tubes are applied. The case, in short, has anæsthesia and hypalgesia of the left half of the face, with narrowing of the left palpebral fissure and smaller pupil, atrophy of the hand and flexor muscles of the forearm, also dissociate paralysis of sensation.

CASE III.—This was a medium-sized, healthy-looking engineer,

aged 25, with good family and previous history. He complained of numbness of left forearm, especially on the ulnar side and in the ring and little fingers. Shortly before, patient had burnt his arm when working around his engine without experiencing any pain, and in fact knew nothing of it till the next day. He had had slight attacks of dizziness and exhibited a tendency to perspire.

Examination shows narrowness of left palpebral fissure and left pupil. The motor power of both hands and arms is normal. Touch and muscular sense normal, while there is very marked loss of perception of the sense of pain and temperature in the left forearm and hand, especially on the ulnar side.

These cases show great similarity of the parts affected, while the disease in the earlier and later stages is well presented. The two first have involvement of the ascending root of the fifth nerve, and all three point to invasion of the cilio-spinal centre. The last two cases might be confounded with neuritis, but the eye and characteristic sensory symptoms together with the absence of pain on pressure over the nerve trunks exclude that disease.

As an indication of the chronic course of the disease, Mendel has pointed out that in 1867 Duchenne showed a case with the diagnosis of progressive muscular atrophy, and Charcot presented the same case in 1889 as one of well-marked syringomyelia.

RETROSPECT
OF
CURRENT LITERATURE.

Medicine.

Treatment of Diphtheria by Antitoxine.

WELCH. "Treatment of diphtheria by antitoxine."—(From *The Johns Hopkins Hospital Bulletin*, Nos. 52 and 53 July and August, 1895.)

The scientific world is becoming daily more appreciative of the practical value and theoretical accuracy of serum therapy—so much so, that to-day few clinicians of note, whose experience has brought them into touch with the new methods of treatment, fail to recognize the epoch-making work on diphtheria antitoxine.

Prof. Welch, in a most interesting series of articles, deals with the subject at some length, convincing his readers that the sum of all our experience hitherto gathered most indubitably favours the use of serum. In an introductory historical sketch he refers to the original investigations of Babes and Lepp in 1889, and points out that Behring and Kitasato in December, 1890, presented the first publication demonstrating the general principles of serum therapy, this being just three years before Roux's memorable address before the Budapest Congress. With reference to the mode of action of the antitoxic serum, he considers the two theories. One, the chemical is based on the principle that the toxine is directly neutralized in a chemical sense. Experiment has already demonstrated the insufficiency of its essential features. The second, or vital theory, is the more natural. It presumes that the antitoxine acts through the agency of the living body, probably rendering the cells tolerant of the toxine. The effect of the serum depends both on the condition and the nature of these cells. They must be able to respond to the stimulus of the antitoxine, else the result will be a negative one. Some types of cells, again, are more susceptible than others to the action of the toxine, e.g. nerve cells, so that they may be destroyed at a very early period, their destruction rendering the antitoxine ineffectual against the nerve tissues thus injured. The antitoxine is not bactericidal though it prevents the development of the local inflammation caused by Loeffler's bacillus.

An interesting comparison follows, showing the identity in essential features between experimental and human diphtheria; an important

difference, however, exists; whereas the experimental variety is almost wholly unattended by complications, human diphtheria not infrequently presents evidences of secondary infections, septicæmias, broncho-pneumonias, etc. Hence, too, the use of the serum in the respective instances varies, for the power of the antitoxine in combating the secondary events is limited, in fact, quite valueless, excepting as a prophylactic. That it should prevent their development is but natural, inasmuch as it antagonizes the causes of the increased susceptibility of the tissues to complications.

The same holds good for individual cells and tissues; once necrosed the antitoxine cannot regenerate them—though its timely administration diminishes the liability to degeneration. The importance of early treatment is strongly emphasized, and the fatality statistics are quoted to indicate the necessity of this rule. In nearly all the series it is shown that patients treated at the earliest manifestation present a far smaller mortality than do those in whom injections were made after several days had supervened.

Further, a sufficiently large dosage is essential to successful results; our methods, hitherto entirely empirical, have been modified according to the age of the patient, and the severity and duration of the disease. The large number of unsatisfactory results in the early days of serum therapy are attributable in no small degree to insufficient dosage.

A large and valuable series of statistics cited affords ample evidence of the success which has attended the employment of the diphtheria serum, and the writer asserts his conviction that the antitoxine is "a specific curative agent for diphtheria, surpassing in its efficacy all other known methods of treatment for this disease. It is the duty of the physician to use it." The paper throughout is one of unusual interest, and the information so concisely put together that any adequate abstract thereof is practically impossible, while the careful perusal of the series will repay the time spent. *C. F. Martin.*

Surgery.

Dislocation of the Ulnar Nerve.

WHARTON, H. R. "A report of fourteen cases of dislocation of the ulnar nerve at the elbow."—*American Journal of Medical Science*, October, 1895.

In this article Dr. Wharton reports one case observed by himself. The patient was a boy aged 15 years, who was struck upon the inner aspect of the right elbow by the point of a stick of wood. Upon the reception of the blow he felt a sharp pain at the seat of injury and noticed a sense of tingling in the inner side of the forearm and in the little and ring fingers. Upon examination some time afterwards, when the swelling had been reduced by hot applications, a cord was discovered in front of the inner condyle, pressure upon which caused pain and tingling in the little and ring fingers. The diagnosis was dislocation of the ulnar nerve. The nerve could be pushed back into its normal position. When the arm was flexed the dislocation recurred. A pad was applied which retained the nerve in its proper place, but upon removal of the pad the nerve invariably slipped forward again upon flexion of the arm. The pain became, however, gradually less, and the parents of the boy declined to have any operation performed.

Dr. Wharton has collected brief reports of thirteen other cases. They all presented the same symptoms. In all of them the nerve could be replaced without difficulty when the arm was in the extended position, and in all of them the nerve slipped forward again when the arm was flexed. In six or seven cases an incision over the back of the inner condyle was made and the nerve inclosed in a sheath of fascia. In all the cases so operated upon recovery ensued. The nerve remained in position and functionated normally.

Dislocation of the ulnar nerve at the elbow is a comparatively rare affection, occurring independently of fractures or dislocations of the bones of the elbow, and may result from direct violence, from muscular effort or violent flexion of the arm at the elbow, causing laceration of the fascia holding the nerve in its groove at the back of the inner condyle of the humerus.

Zuckerkandl, in an examination of two cases of dislocation of the ulnar nerve in dead subjects, noted that the internal condyle of the

humerus in each of these cases was small and the groove for the nerve shallow, and the fascia binding down the nerve was poorly developed; an unusual forward position of the internal lateral ligament was also noted. In view of the possibility of the development of a neuritis it seems wise to replace the dislocated nerve and fix it in its normal position as soon as possible after the injury. In all the reported cases where the nerve was exposed and sutured in its normal position, the result was satisfactory and the dislocation did not recur, and in no case is it recorded that neuritis developed in the nerve as a result of operative treatment. *G. E. Armstrong.*

Pharmacology and Therapeutics.

The Treatment of Diabetes Mellitus.

WEST. "Treatment of diabetes mellitus by uranium nitrate."—*The British Medical Journal.* August 24, 1895.

ROBIN. "The alternating treatment of diabetus mellitus."—*Bulletin de l'Academie de Médicin*, No. 23, 1895; *Boston Medical and Surgical Journal*, August 29, 1895.

CASSAET. The treatment of diabetes mellitus by the administration of brewers' yeast."—*La Presse Médicale*, August 24, 1895.

After a short summary of the few facts known about the physiological action of uranium nitrate, Dr. Samuel West, of St. Bartholomew's Hospital, in a paper read at the last meeting of the British Medical Association presents the results of his investigations on the action of this drug in diabetic patients. He commenced by administering the drug to a number of diabetic out-patients, beginning with small doses and gradually increasing them, watching the effect. He found that after the administration of the drug for a short time all the patients, without exception, stated that their thirst was greatly relieved, and the frequency of micturition and the quantity of urine passed greatly reduced. As the results promised well, he instituted a careful investigation by making daily a examination of the urine of several patients, whom he took into the wards of the hospital for that purpose. One patient he had under observation for more than twelve months, and during that time an almost daily examination of the urine was made, and a careful record kept of the patient's weight, diet, and general condition. Another case, a private patient, was also under observation for a long time. In both an effort was made to place the patient under constant conditions, so that the only difference should be the administration or withholding of the drug which was under investigation. Detailed notes are given of both these cases. The results obtained, says the writer, leave us no reason to doubt that we have in uranium nitrate a drug which has a powerful action in influencing some of the more prominent in that group of symptoms known as diabetes. As to the mode of action we can only speculate. Dr. West thinks it likely that the action is due to the effect it has in

checking the digestion of starch and of some forms of albumin, and in controlling excessive pancreatic digestion.

As to the size of the dose, care must be exercised. Experimentally it has been proved that uranium nitrate is an irritant poison, and its prolonged administration in full doses may be followed by albumin in the urine, due to an irritative and destructive action on the renal epithelium. Chittenden states that if the albuminuria produced by a certain dosage is allowed to disappear by suspending its administration, the drug can then be given again, and increased to ten times the amount, before albumin again appears. In none of the writer's cases did albumin appear in the urine at any time; this he attributes to the administration of the drug in small doses, which were only gradually increased. He also thinks it possible that when an effect is once produced by the drug upon the disease it can be maintained by continuing its administration in smaller doses. He is also inclined to think that the effect is not entirely dependent upon the amount administered each day, but that small doses, although taking longer to act, may have almost as efficient an action as larger ones. As to the method of administration, he states that the nitrate is best given freely diluted with water and after food, commencing with a small dose of one or two grains twice daily after the chief meals, and increasing the quantity slowly at intervals of a few days until its effect is produced. Thus given he has not found it disturb the digestion, or cause any irritation of the stomach or bowels, and albuminuria has in no instance been induced.

Dr. Albert Robin, editor of the *Bulletin de Thérapeutique*, believing that in many cases of diabetes there is an over-activity of nutrition in general and of the hepatic cell in particular, the result of continuous nervous excitation, direct or reflex, recommends the administration of drugs which diminish the activity of this metabolism by acting primarily on the nervous system, and thus describes a treatment carrying out this idea in three alternating stages. He begins by a week of dietetic regimen, in which the rigorous principles of Bouchardat are enforced. A careful quantitative analysis of the urine is then made and the amount of sugar noted. Should the sugar have entirely disappeared, no medical treatment is advised, but the patient is directed not to vary for a long time from the prescribed diet. In general, the sugar is only diminished in amount, and the patient then begins the first stage of the medicinal treatment. In this a powder containing fifteen grains of antipyrin with eight of sodium bicarbonate, is directed to be taken twice daily, one hour before breakfast and before dinner, in a little mineral water. At the same time

cod liver oil in moderate doses should be taken with the meals, and a full dose of Rochelle salts as a daily morning purgative in the event of constipation. On the fourth or fifth day this treatment is suspended, and quinine, which is believed to lessen organic destruction, is prescribed in a dose of six grains, with the mid-day meal. It is directed to be taken for six days, then discontinued for four days, and again taken for six days. At the same time with breakfast and dinner is taken a cachet containing arseniate of soda, carbonate of lithium and codeia, all of which are supposed to diminish the "activity of the tissues and retard nutritive mutations." The cod liver oil is continued if well borne. After fifteen days the medicines of the second stage are dropped and the patient commences those of the third stage, namely, opium and belladonna, bromide of potassium, the alkalies, and valerian, all being "moderators of the exchanges." These are administered as follows: For eight days a pill containing extract of opium, belladonna and valerian is given every six hours for the first and second days, every four hours for the third and fourth days, every three hours for the fifth and sixth days, and again every six hours hours for the seventh and eighth days. During this period the patient is directed to drink freely of boiled water containing about a drachm of sodium bicarbonate to the pint. The cod liver oil is discontinued, and if there is any intolerance of the opium and belladonna, bromide of potassium is substituted in fifteen grain doses. On account of the loss of inorganic salts in diabetes the author endeavours to maintain the supply by a liberal use of green vegetables and by directing that salt be taken freely with the food.

If sugar is still present in the urine after the completion of this course, the series is recommenced. After a second course, whether the sugar has disappeared or not, a respite from all medical treatment for a month should be directed, and a strict diet maintained. During this month of interruption the patient, if still azoturic, should continue the use of the alkaline waters. If, however, the proportion of urea falls below the normal, the alkaline waters are stopped, and some ferruginous preparation given instead. If during the treatment the sugar disappear from the urine, the return to ordinary diet must be very gradual, demanding at least six months or a year.

Dr. Robin has tried this plan of treatment (which has taken several years in its elaboration) on 100 cases of true diabetes, in each of which the excretion of sugar exceeded 100 grammes (3½ ounces) in the twenty-four hours. Considerable and permanent amelioration, conditional on careful dieting, with occasional resumption of the treatment, has been noted in 33 of these. In 24 cases a definite cure has re-

sulted, in 25 recovery is still doubtful, and in 18 the results have been negative or only temporary.

Dr. Cassaet also read a paper at a recent meeting of the *Congrès Français de Medicine Interne*, on the results obtained by the administration of brewer's yeast in diabetes. It was given in doses of an ounce and a half at meal time. Although at first it gave rise to eructations, and, later on, diarrhœa, tolerance was established in a few days, and an improvement in the general conditions was noted.

Action of Antisudorifics.

SEMMOLA. "A clinical study of the antisudorific properties of picrotoxine."—*The Lancet*, September 14, 1895.

In a very interesting paper read at the Institution of Clinical Therapeutics of the Royal University of Naples, Dr. Semmola points out the various means by which the function of perspiration is regulated. A special system of secreting nerves appears to preside over it, which although closely associated with the vaso-motor system is, nevertheless, independent of it, as is evidenced in the perspiration which takes place with a pale skin in cases of strong emotional excitement, or in the death agony. This fact has also been verified by the induction of perspiration in an amputated limb. Sudorific centres have also been discovered; in the cat a lumbar centre has been shown to influence the posterior limbs, and a cervical centre the anterior ones, while a bulbar centre, influencing all four limbs, has been demonstrated, which, under stimulation, may produce perspiration three-quarters of an hour after the death of the cat. Generally, however, perspiration is in direct proportion to the quantity of blood distributed in the surface of the skin. It is therefore clear that this secretion may be influenced in various ways, and the several agents in our pharmacopœia which act on this function may do so in differing methods. Some may act by increasing the mass of blood, as in the case of copious draughts of hot water, or by exciting the action of the heart as in abundant potions of warm spirituous liquors. Others, again, such as muscarine, nicotine, or acetate of ammonia, may act by stimulating the sudorific centre; or the whole of the secreting nervous apparatus, both central and peripheral, may be stimulated, as by pilocarpine; or, lastly, the vaso-motor system may be paralyzed, as by antimony or ipecacuanha. On the other hand, antisudorific effects may be obtained from drugs acting very variously. Agaricin and agaricic acid possess a paralyzing action on the peripheral apparatus of the sweat secretion. Camphor and camphoric acid act as

general stimulants to the nervous system. Atropine paralyzes the secreting nerves, while picrotoxine acts by first stimulating the vaso-motor medullary centre, and afterwards constricting the vessels. Before, therefore, the physician institutes an antisudorific treatment he should form a clear conception of the pathogeny of the disturbance in the secretion, and according as to whether the nervous sudoral apparatus, the vaso-motor system, or the smooth fibres of the blood vessels, are affected, he should chose that agent which will directly counteract the pathological condition present. Thus when treating an ephidrosis due to excitement of the sudoriparous nervous system, we must have recourse to those medicines which, like agaricin, atropine, &c., have an inhibitory action ; when we believe the ephidrosis is due to paralysis of the vaso-motor centre, we should administer stimulating remedies, such as picrotoxine ; and, lastly, if there is a diminution of vascular tone from peripheral disturbances, we should then use hydrotherapy, which has a marked action on the vascular walls. Guided by these ideas we may obtain excellent results in cases where many remedies given in a merely empirical method have failed. The writer details the case of a patient with valvular disease of the heart, and great prostration following influenza, in whom ephidrosis persisted, and was associated with livid red erythematous patches on the skin. Picrotoxine was prescribed as a stimulant to the vaso-motor centre, and the perspiration rapidly diminished in amount, and disappeared on the eighth day of treatment.

Tongue Traction.

McCallum, H. A. "Tongue traction as a cardiac stimulant."—*The Medical News*, September 28, 1895.

Dr. McCallum, of London, Ont., states that as a result of experiments upon animals, he places considerable confidence in this measure as a stimulant, not only to respiration, but also to the heart's action. He finds that it increases not only the rate of an exposed and failing heart, but also the vigour of its contractions. At first he thought that this effect might possibly be due to a lowering of the blood pressure, through the tissues of the neck acting as a pump on the carotids and aorta, or through inhibition of the vaso-constrictor centre. To determine whether this was a correct explanation, some animals were allowed to die of hæmorrhage, but it was found that in these the effects of tongue traction were, if anything, even more marked than in animals dying with cardiac distension. In some cases he divided both the vagi, without appreciably altering the results. He was,

therefore, led to conclude that the stimulation was due to an action on the cardio-accelerating centre in the medulla.

Laborde spoke in the most confident terms of the superiority of this method of restoring cases of asphyxia, and the writer is satisfied that it will succeed in many cases, even when other methods fail, since it acts both as a respiratory and cardiac stimulant. It may be combined with a good method of artificial respiration in anæsthetic accidents, cases of drowning, asphyxia, and syncope from any cause.

It appears, however, easy to exhaust the effect on the medulla, for it was noted that, if tongue traction be practised on the animal before the heart ceases to beat, it is powerless to restore the contractions, when the heart has once stopped.

A. D. Blackader.

Gynaecology.

Hydrosalpinx.

CULLEN, T. S. "Hydrosalpinx."—*Johns Hopkins Hospital Reports.* 1895.

In this exquisitely illustrated report, Dr. Cullen deals with eleven cases occurring in the Johns Hopkins Hospital, and with these as his text, he passes on to discuss the subject in all its bearings.

The tube at its uterine extremity is usually small, and after following a tortuous course outwards, rapidly or gradually dilates, the dilated portion presenting three or four constrictions, with corresponding bulging. This has been likened to a coil of intestine. Some specimens have assumed the shape of a pipe, the occluded fimbriated extremity corresponding to the bowl. The tube usually is found lying low down in Douglas cul-de-sac.

A dilated tube of this nature has a size of a small orange to that of a child's head. Tumours of immense size are also reported, notably one by Peaslee containing eighteen pounds of fluid. Bonet reports one containing thirteen pounds of fluid.

The tube is usually bound down by adhesions to the ovary and surrounding structures, and the omentum is found attached. The uterine end of the tube is usually free, while the fimbriated end is fixed. Occasionally the whole tube may be absolutely free from adhesions. In six out of the eleven cases small sub-peritoneal cysts containing clear fluid were found close to the outer end of the tube.

Förster states that hydrosalpinx is usually double, but from later experience of other gynæcologists it would seem that one-half of the cases are unilateral, while the other half are biiateral.

The walls of the tube are usually very thin. One case is reported where a calculus was found within the lumen of the tube. If the tube has been ruptured during extraction it will contract to its original size and thus probably deceive the operator. The fluid is generally pale straw colour, but sometimes tinged with blood.

The classification given by Cullen is as follows:

1. Hydrosalpinx simplex.
2. Hydrops tubæ profluens.
3. Hydrosalpinx follicularis.
4. Tubo-ovarian cyst.

The gross appearance of the first variety agrees closely with the general description already given. That is to say, the uterine end is usually normal in size; as it passes outward it becomes slightly convoluted, and gradually or suddenly dilates, increasing in size until the occluded, fimbriated end is reached. The tube, as a rule, is found low down in Douglas' cul-de-sac. The tube is usually adherent.

The author describes twenty-one cases of this variety, including the one in which there was a tubal calculus.

Hydrops Tubæ Profluens.—This term has been given to a variety recognized by the escape of fluid from the tube into the uterine cavity periodically. The variety is rare. Martin reports four cases in 500 of tubal disease.

Hydrosalpinx Follicularis.—In this variety the tube is usually of small size, and in one case did not reach more than 3 cm. in diameter.

Externally it differs in no way from the simple variety. *On section, however, it presents a honey-combed appearance, and may or may not show a central lumen.*

Scattered throughout the central zone of the tube are oval and round spaces, varying from a pin-point to 8 mm. in diameter. These cavities are filled with fluid and apparently communicate with one another. Three cases of this variety are reported.

Tubo-ovarian Cyst.—In this variety the dilated tube communicates with an ovarian cyst, the fluid contents passing from one cavity to the other. The first thing that attracts attention is the cyst, which may vary in size from a walnut to a child's head. Coursing along its upper surface is the Fallopian tube, which may be normal in size at its uterine end. As it passes outwards the tube dilates and terminates in a dome-like extremity which, by its under surface, is intimately adherent to the cyst. The ovarian cysts may be unilocular or multilocular and of various sizes. Cullen states that three of eleven cases were tubo-ovarian. These cases are given in detail in the report.

The Fluid.—According to Hammersten this is a watery serous fluid containing albumen, but not containing a pseudo-mucin.

Etiology.—The causes of hydrosalpinx are extremely vague and uncertain of proof. It is thought, however, by the majority of observers, that it is due to occlusion of the fimbriated end of the tube by inflammatory action set up by many accidents. Pyosalpinx may degenerate into hydrosalpinx by absorption of the pus cells through a process of fatty degeneration (Landau). This is not generally credited, however.

The follicular variety is thought to be due to a previous endosalpingitis, the mucous folds of opposing sides of the tube becoming

adherent, and in this way giving rise to the honey-combed appearance on section.

The tubo-ovarian variety results from the tube becoming adherent to the ovary containing a Graafian follicle. Both gradually dilate and pressure causes absorption of the intervening wall.

Origin of Fluid.—Interesting experiments upon rabbits and guinea-pigs have shown that by ligaturing the tube at each end we can produce a hydrosalpinx through the accumulation of the normal fluid.

Symptoms.—These are very indefinite and indeed may be entirely absent. Usually they are those of ordinary inflammatory pelvic disease. The effect on menstruation is also very various and cannot be relied upon in making a diagnosis. The patients are usually sterile. Vaginal examination shows the uterus to be very sensitive and enlarged. Passing outwards from the fundus uteri the enlarged tube can be felt. It is sometimes elastic and will force the fundus forward again when pressed back against it.

Treatment.—The report describes some valuable points in the operation of abdominal section necessary in such cases.

T. Johnson-Alloway.

Pathology.

Recent Studies upon Jaundice.

VAUGHAN HARLEY. "Leber und Galle während dauernden Verschlusses von Gallen und Brustgang."—*Archiv. für Anatomie und Physiologie. Physiolog. Abtheilung*, 1893, page 291.

STADELMANN. "Der Icterus und seine verschiedene Formen." Stuttgart, 1891.

WILLIAM HUNTER. "The action of Toluylenediamin."—*Journal of Pathology*, Vol. III., No. 3, July, 1895, page 259.

Until very recently, jaundice was held to be of two main varieties, hepatogenous and hæmatogenous, the former due to obstruction to the flow of bile from the liver, and to consequent absorption into the blood, the latter due to the transformation of the blood pigment of destroyed blood corpuscles into bile pigment in the circulation, or, as Osler expresses it, to a suppression of the functions of the liver cells, as in the widespread necrosis of acute yellow atrophy, or to an excess of the chromatogenous material, as in malaria, in which the liver functions cannot keep pace with the blood destruction. Concerning the existence of the former, or obstructive jaundice, our views at the present day are in no wise altered, save to the extent of being expanded. Vaughan Harley's researches show us more clearly than heretofore the path whereby the bile, prevented from passing into the intestinal canal, gains entry into the blood and so becomes diffused throughout the system. The current opinion had been that, while possibly the lymphatics of the liver might play some part in conveying away the excess of bile in the organ, the main channel and the natural channel, whereby the bile salts and pigment enter the circulation, was to be found in the remarkably rich portal capillary circulation. Von Fleischl, Kunkel and Kufferath had already before Harley made observations to determine the point and they had shown that bile can pass from the liver by the lymphatics when the common bile duct is obstructed. Harley confirmed the earlier work; he found that if the common bile duct be ligatured the bile salts and pigment pass very rapidly into the blood and so into the urine. In fact, very shortly after the operation they are to be detected by delicate methods. Advancing further he found that if the thoracic duct be also ligatured

no jaundice sets in, and for periods as long as seventeen days not a trace of bile pigments might be detected in the urine. The urine, it may here be added, shows far sooner than does the blood the presence of these constituents of the bile. Unfortunately in seven out of ten of Harley's experiments, in which the thoracic and bile ducts were ligatured at the same time, there resulted a rupture of the latter, in consequence of the great pressure of the contained bile. This rupture took place at periods varying from two to seventeen days and led naturally to a failure of the observations beyond the time of outflow of the bile into the abdominal cavity. Rupture could be prevented by first ligaturing the common bile duct, and then a week or so later performing the same operation upon the thoracic duct. Eight experiments of this nature were performed, and in three of the eight the bile which had been present in the urine after the first ligature disappeared after the second, reappearing again several days later. In the other five cases the urine never became free from bile. The general conclusions to be gained from these experiments are that the normal path whereby bile leaves the liver, after obstruction of the common duct, is not by the hepatic veins, but along the lymphatics, and that if the main lymphatic trunk be ligatured jaundice often does not supervene for several days, that sooner or later after ligature of the thoracic duct the lymph (as shown by dissections) finds collateral channels for entry into the innominate vein, and that then only does jaundice manifest itself.[1]

With regard to the various forms of the second variety, the so-called hæmatogenous jaundice, the work of the last few years has been distinctly unsettling; so that at the present time there are those who debate as to whether there is truly such a form, who hold jaundice to be produced only by pigment elaborated in the liver cells, and who are inclined to consider that all forms of icterus are primarily obstructive and so hepatogenous. This alteration in the views regarding jaundice has been due in the main to the observations of Afanassiew and Stadelmann upon the icterus produced in poisoning by toluylenediamin, phosphorus and arseniuretted hydrogen. The observations of these two observers have been notably advanced by Hunter. Afanassiew showed that the first of these drugs exercises a markedly destructive action on the red corpuscles—an observation that has been since

[1] Ziegler has recently contested the validity of Harley's results, and pointed out that masses of bile pigment may be found in the intra-acinous blood capillaries in cases of jaundice. He concludes that bile in these cases enters the circulation by rupture of the distended bile capillaries. Several objections can be brought against this view, of which the most convincing are the rareness with which indications of such rupture are to be met with in the liver and the very striking success of a large number of Harley's experiments. Nevertheless, the possibility of such rupture must not be left out of account.

repeatedly confirmed. Stadelmann showed that when it is introduced into the system well-marked changes occur in the bile. In the first stage this is increased in quantity and is very rich in bile pigments, then follows a second stage during which it loses all the characters of bile and is replaced by a small quantity of viscid colourless mucus. This change begins in the dog about the fourteenth hour and it lasts until the third day, after which the bile gradually returns to its normal character. With these changes in the bile jaundice is very evident, beginning during the first stage, reaching its maximum during the second, and gradually disappearing during the third. It would seem, therefore, that the drug causes destruction of the blood, the hæmoglobin set free leads to an increased formation and excretion of bile pigment, the character of the bile is altered in the direction of increased viscidity, which in consequence of the low pressure at which bile is excreted causes a temporary obstruction and leads to a reabsorption of the bile along the lymphatics. Here, then, if this view of Stadelmann be correct, the icterus which at first sight has all the characters of a hæmatogenous jaundice depends really upon intimate changes in the character of the bile, leading to a temporary arrest of its flow.

Another form of jaundice, that in phosphorus poisoning—which is so similar to that of acute yellow atrophy, and which is associated with lesions in the liver so similar to those of the latter disease that some have regarded the two conditions as identical—presents characters which have always led to its being regarded as the typical hæmatogenous jaundice; yet studying the action of the drug Stadelmann has found that phosphorus induces similar changes to those set up by toluylenediamin, differing only in the one respect that they are slower in their development. The same is true in the case of arseniuretted hydrogen. There are other ways in which profound destruction of the red corpuscles may often be induced with associated development of jaundice, such as the injection of water or hæmoglobin into the circulation, the inhalation of ether and chloroform, extensive burns, poisoning by pyrogallic acid and naphthol, and the jaundices so produced, as also those of paroxysmal hæmoglobinuria, pernicious anæmia and malaria, have all been classed as examples of hæmatogenous icterus. These observations of Stadelmann would seem at first sight to render it extremely doubtful if any single one of them be not truly hepatogenous, or, as Afanassiew would term it, hæmohepatogenous.

Hunter's observations, which have been carried on since 1888 and are a continuation of his well-known studies upon pernicious anæmia,

show that the concentration of the bile, which is so characteristic a feature in the first form of jaundice above mentioned (toluylenediamin is a painful word to repeat too frequently), is due to an extensive catarrh of the bile ducts extending from their origin downwards towards the duodenum and occasioned by the excretion of the poison or its derivatives through the bile.

In all cases following the injection of the drug he found a condition of congestion and catarrh of the mucous membrane of the duodenum, having its greatest intensity around the opening of the bile ducts. The drug had been given hypodermically, and so could scarce have acted directly upon the intestinal mucous membrane, while the swelling and catarrh was equally manifest along the course of the bile duct. What is more, as early as one hour after injection traces of the drug could be detected in the bile. Hunter, however, considers that the irritant action of the bile is not due to the poison itself, but to its derivatives, for his researches show that a singularly small proportion of the drug is obtainable from any of the excretions; it would appear to undergo rapid conversion into derivatives. He does not consider that the involvement of the duodenum is anything but a mere adjunct to the catarrh of the bile ducts. According to him, therefore, the jaundice in question is a catarrhal jaundice, differing in character from the ordinarily accepted catarrhal jaundice by spreading downwards from the small bile capillaries, rather than upwards from the duodenum, and, again, in being associated with destruction of the red corpuscles.

From this point Hunter passes on to consider what is the relation between increased destruction of blood and jaundice. He shows that simple excess of free hæmoglobin in the blood, even in quantity sufficient to cause hæmoglobinuria, does not necessarily of itself suffice to cause jaundice. The very drug with which he has worked causes jaundice without hæmoglobinuria in dogs, hæmoglobinuria without jaundice in cats, while in rabbits it apparently causes neither the one nor the other, and yet in all three classes it occasions a destruction of the red corpuscles. He discusses whether the occurrence of icterus after an increased blood destruction may be dependent upon the form in which the blood pigment removed from the corpuscles is supplied to the liver, and points out that under the action of his drug the hæmoglobin does not become dissociated from the albuminous stroma of the corpuscles, as it does when distilled water is introduced into the circulation, but remains attached to this in a modified form, appearing as minute yellowish spherules. Nevertheless, jaundice may be produced by agents which do not lead to this peculiar modification of hæmo-

globin. Hence he concludes that this alone will not suffice to explain, and he is driven back upon an assumption, satisfactory in some respects, but unsatisfactory so far as it remains an assumption, that jaundice, apart from the usually accepted obstructive form, depends upon capacity of the poison occasioning the blood changes to excite catarrh of the bile ducts.

Both Stadelmann and Hunter are, however, it may be, a little too advanced in their views as compared with the basis of facts upon which those views are founded. It is true that they have proved that a considerable and important number of cases originally classed as hæmotogenous jaundice can no longer be rightly regarded as such. But must we give up entirely the class of jaundice produced essentially by hæmolysis and production of pigment in the blood? Is it not possible that certain (icteroid rather than icteric) conditions are in reality not dependent upon abnormal change in the liver itself, even if some change be present therein? Certainly a main function of the liver is to remove modified blood pigment from the circulation, but is it capable of removing all such pigments? It has still to be shown, so it seems to me, that that the icteroid condition associated with malaria and pernicious anæmia is clearly due to deranged function of the liver. It may be that this is the case, but our present assumption that it is, is based upon a chain of reasoning in which some of the links are imagined rather than properly forged.

Thus, then, the results of the last few years lead to the following modifications of Murchison's classification of forms of jaundice:

I. *Hepatogenous icterus, (due to obstruction of the biliary passage pure and simple, without associated destruction of the red blood corpuscles.)*

1. By foreign bodies—gall-stones and parasites.

2. By inflammatory tumefaction of the duodenum and duct ("catarrhal jaundice").

3. By stricture and cicatricial obliteration of the duct.

4. By tumours closing the orifice or growing within the duct.

5. By pressure on the duct from without.

II *Hæmo-hepatogenous icterus, (due to excessive destruction of the red corpuscles, with accompanying (catarrhal) obstruction of the bile capillaries).*

1. By poisons—phosphorus, arseniuretted hydrogen, toluylenediamin, pyrogallic acid, etc.

2. Acute yellow atrophy of the liver (by analogy with phosphorus poisoning).

3. In extensive burns and scalds (Hunter).

III. *Forms of icterus in which the pathology has not yet been satisfactorily elucidated.*

1. Epidemic jaundice and Weil's disease. These conditions are almost certainly hepatogenous and should probably form a sixth class in division I., namely, that of obstruction due to catarrh of the bile capillaries.

2. Jaundice of paroxysmal hæmoglobinuria.

3. Icterus neonatorum, benign non-septic cases.

4. Jaundice following upon injection of water, glycerine, etc.

5. Jaundice of yellow fever.

6. Jaundice of pyæmia and septic fevers.

7. Icterus neonatorum, septic cases. (In all these, from 2 to 7 inclusive, we are probably dealing with hæmo-hepatogenous cases although it may be that 5, 6 and 7 are with epidemic icterus to be classed in a special division among the hepatogenous.)

8. Jaundice of malaria (not including catarrhal duodenitis complicating the disease).

9. Jaundice of pernicious anæmia.

10. Icteroid conditions associated with wasting diseases.

The balance of evidence is perhaps in favour of grouping 7, 8 and 9 with the hæmo-hepatogenous, nevertheless evidence is still wanting to prove any obstruction to the excretion of bile pigments in these cases, or any back flow of bile from the liver cells.

There is great difficulty in properly classifying certain categories of jaundice, *e.g.*, the malarial and icterus neonatorum. This is due to the fact that the condition may be of several forms. Thus, for example, Icterus neonatorum may be (1) benign, (2) septic, (3) obstructive, (congenital) from syphilitic hepatitis, &c.

J. G. Adami.

Ophthalmology.

Ophthalmia Neonatorum.

COHN, HERMANN. "Zur Verhütung der Augeneiterung der Neugeborenen."—*Centralblatt für Augenheilkunde*, April and May, 1895.

SILEX, P. "Statisches über die Blennorrhœ der Neugeborenen."—*Zeitschrift f. Geburshilfe u. Gynœkologie.* XXXI. Heft 1. 1895.

MAY, CHAS. H. "The prevention and treatment of ophthalmia neonatorum and the necessity for more efficient legislation to prevent blindness from this cause."—*Medical Record*, Feb. 16, 1895.

That we are far from the desired for perfection in the prevention and treatment of this direful malady, the publication of the above articles during the past year strikingly evinces.

Cohn's paper is rather of the character of a defence of the Crede method, and is the outcome of the congress of the medical section of the Silesian Society in January last. At this congress Keilmann claimed a great immunity at the University woman's clinic, as resulting solely from the careful washing of the eyelids immediately on the birth of the child's head. He saw no case of primary infection among 500 cases of childbirth. Cohn states that in the five periods between 1886–90 the percentage in his hospital practice were 17, 19, 16, 12 and 10 per mille, but in 1894 again 12 per mille, and in private practice 9, 6, 5, 4 and 3 per mille, and in 1894 again 3 per mille. Hence during the latter period there was no diminution. Silex in his article places his figures at 12 per mille in 1878 before Crede's method was employed, and in 1889 to 1894 still 10 to 12 per mille. This was obtained from about 100,000 patients in the Berlin University Clinic.

In opposition to all this Haab firmly states that in the lying-in institution the percentage of cases before Credes method was employed was 9 per mille, but since its employment only 1 per mille. In the hospitals cleanliness and watchfulness can avoid the epidemics formerly so common. The mother must be warned against the danger of infection, and any suspicious case should be isolated and treated with nitrate of silver. All the nurses must be well-drilled, cleanly women.

As to primary infection from the mother's passage, we should begin prophylaxis by preventing a man having gonorrhœa from marrying

until he is clear of the complaint. If, however, the mother is already infected, the prophylaxis must begin with her in disinfection of the vagina with antiseptic douche, etc., some even going so far as to "scrub out" the vagina with soap and brush. Some obstetricians advise no drug. Thus we see there is a marked lack of unity on this point, but all are agreed as to the necessity for disinfection of the child's eyes, the only question being how.

As the gonococci are on the skin of the lids and on the lashes they get into the eyes on the first opening of the lids. Hence the mechanical cleansing of the lids is the first consideration. This is the method by which Keilmann claims his success, whereas it has failed with other obstetricians. Accordingly the latter have sought for surer means and have tried washing out the eyes carefully with distilled water and cleansing the head with dry napkins (not with the bath water, which may contain washed-off gonococci). Carbolic acid, salicylic acid, sublimate, thymol, etc., have been recommended and again abandoned.

Only Credé's method has been really successful, and it must be employed accurately, as he advised in 1882, as follows: "After tying the cord the child's body is wiped free of the vermix, mucus, etc., then put in a bath, the eyes and eyelids are forthwith cleansed with a fresh napkin, or better, clean absorbent wool, not with the bath water, but with fresh clean water; then open the lids and gently instil one drop of a 2 per cent. solution of nitrate of silver. Any further consideration of the eyes is unnecessary. For instance, if in 24 to 36 hours a slight reddening and swelling of the lids accompanied by secretion of mucus occur, the instillation need not be repeated."

Crede out of 1,160 children had only one case of blenorrhœa, and this resulted from overlooking the instillation of the nitrate of silver.

Cohn considers that the failure or only partial successes of this treatment in other men's hands results from carelessness in some detail on the part of the practitioner or nurse. He emphasizes particularly the necessity of deft, neat-handed nurses, to avoid any chance of abrasion of the cornea, as he rightly considers that the keratitis, which some practitioners complain of as being caused by the nitrate of silver, is solely due to the rough handling on the part of the doctor or nurse. He and Fränkel assert that the nitrate of silver in 2 per cent. solution can amply protect the eyes and yet only cause a slight catarrhal conjunctivitis which disappears on ceasing to use it.

Some assert that the nitrate of silver favours the gonococci through setting up this catarrhal conjunctivitis; accordingly if one eye is already infected, and the other uninfected eye is protected by the instillation of nitrate of silver solution, the gonococci should rapidly

spread to and flourish in this second eye—which, however, is not the case.

Cohn holds that any weaker solution than 2 per cent. is useless, for experiments have shown that the 2 per cent. solution destroys the gonococcus in two seconds, whereas weaker solutions require half to one minute. This use of weaker solutions is the cause of non-success in many cases.

He urges the education of the masses up to the fact of the danger of this eye disease. In Havre, on the notification of the birth of a child, a pamphlet is handed to the persons so notifying with directions as to the treatment of any suspicious eye trouble, and Fränkel has gone so far as to advise the sending of copies to any married couple. In Silesia any purulent eye inflammation in the new-born must be reported forthwith or else a fine is imposed.

At the end of the Congress a commission of medical men was appointed to gather as accurate statistics as possible, and formulate rules for the prevention of this disease.

Cohn finishes his article by saying that blennorrhœa neonatorum can and must disappear from all civilized states. The sum total so far is the cleaning of the unopened lids immediately the head is born, followed by the regulation Crede procedure so soon as the cord is divided.

Dr. May has the same story to tell as has Silex and others: the disease is not less frequent in the Ophthalmic Hospitals since the introduction of the Crede treatment. In some cases saturated boracic acid solution was used instead of nitrate of silver and with good result. The treatment is the hourly and careful washing out of the eye with a saturated boracic acid solution when once the disease is started, and iced application at the outset if much swelling of lids be present, also the daily instillation of 1 per cent. nitrate of silver solution.

May advises the enaction of strict laws as to the reporting of cases and their ensuing treatment.

Infection of the Eyes.

PERLES, MAX. "Experimentelle zur Lehre von den Infections Krankheiten des Auges."—*Virchow's Archiv.* CXL. P. 209.

At the early death of this talented author a large mass of experiments and studies, complete and incomplete, were left unpublished. These have now in part been brought to light in *Virchow's Archives.*

The experiments were mainly on rabbits' eyes, and were conducted with the greatest care. They prove that pure cultures of

the hay bacillus, of yellow or orange sarcinæ, of saprophytic (not pathogenic) bacilli from decaying sea fish, and finally of the cholera spirillum, inoculated into the anterior chamber or into the vitreous, gave rise to no characteristic lesion of theeye- ball, or at most, occasionally set up a fibrinous hæmorrhagic iritis with synechia. Typhoid bacilli from fresh, strong, virulent cultures injected into the anterior chamber caused hypopyon and occlusion of the pupil by a membrane, but they disappeared in three days. Inoculation into the vitreous produced suppuration, and in the pus, bacilli were found free or enclosed in cells. Cultures of streptococci injected into the anterior chamber caused an exudation into the pupil and chamber, but pus containing streptococci led in twenty-four hours to severe iritis septica, and injection of it into the vitreous caused suppuration. Fresh virulent diphtheria bacilli in the anterior chamber set up purulent exudation (in which within two days the bacilli die) with a kerato-iritis; in the vitreous the same caused suppuration.

Friedländer's pneumo-bacillus is the worst enemy of the eye; the slightest trace inoculated into the vitreous sets up the severest panophthalmitis, which within sixteen hours can go on to perforation of the eye-ball; the same result, but less virulent, occurs on inoculation into the anterior chamber. Inoculation into the cornea causes a characteristic ulcer which can cicatrize; from the intact conjunctiva no infection follows the presence of this pneumo-bacillus. None of the animals suffered general infection. Directly opposed to this is the result of the inoculation with the Fränkel-Weichselbaum pneumococcus in the eye; here in a few days the animal dies of general infection, and only after cultivation of the coccus on eggs did he succeed in getting the virulence sufficiently attenuated, so that inoculation only caused loss of the eye from panophthalmitis, and not death of the animal from general infection. Whilst pneumo-cocci are generally only virulent in the fresh condition, the pneumo-bacilli retain their virulence for months in agar or gelatine.

The pneumo-bacilli are found in thick heaps typically encapsuled in conjunctival pus, often enclosed in cells; in the cornea, in clumps in the lymph spaces; in the anterior chamber crowded between the pus cells and thence soon passing between the ciliary processes. In exceptional cases they multiply in the vitreous and spread into the retina, but the choroid and vessels remain free. This bacillus is by no means uncommon in the mouth, especially in cases of ozæna, hence in cases of infectious eye disease cognizance must be taken of this factor.

The statement of the results obtained by Perles is followed by

a description of his methods and technique, containing much valuable information.

Conjunctival Diphtheria.

JESSOP, W. H. "Two cases of diphtheritic conjunctivitis treated by Klein's antitoxin."—Read before the Ophthalmological Society of the United Kingdom, January 31st, 1895.

RECKEN, W. "Behring's Heilserum bei Diphtherie der Conjunctiva."—*Centralblatt für Augenheilkunde.* 1895.

MORAX, V. "Four cases of diphtheritic conjunctivitis treated with antitoxin serum."—*Annales d'Oculistique*, Vol. CXIII., No. 4.

Jessop's cases were two boys. One, 19 months old. had a patch on the uvula and on the upper and lower palpebral conjunctiva of the left eye. Three injections of Klein's antitoxin were given, 1½ drachms in all. The membrane disappeared without leaving any conjunctivitis behind in five days. There was no local treatment of the eye except distilled water. The second case, 8 months old, had membrane on both eyes and purulent discharge from nose; parotid lymphatic glands enlarged. Two injections of one drachm in all were given. The membrane disappeared in 4 days. Lœffler's bacilli were found in great quantities in both cases.

Recken's case was a boy of 1½ years. He did not use the injection until two days after he had seen the child, and diagnosed the case in the meantime. The right eye had lost the most of its vision by the perforation of an ulcer, and the left eye, which was at first comparatively free, became severely affected. Recken, however, considered the membrane was not so firmly attached in the left eye, although the inflammation remained at its height 10 to 12 days. The left eye escaped ulceration. Whether the comparative failure was due to the tardiness with which the serum was used, or to the nature of this serum, must be an open question.

Morax's cases were four children of 10 months to 6½ years. In three there was nasal diphtheria, and in the eldest laryngeal diphtheria requiring tracheotomy, and also broncho-pneumonia, yet all recovered. There were no corneal lesions in any of the cases.

A Measure for Eye-Strain.

KATZ, R. "Uber das Blinzeln als Massstab für die Ermüdung des Auges."—*Klinische Monatsblatter*, May 1895.

Katz starts by mentioning that tiring of the eyes in reading is due to the irritation of the following ocular apparatus: 1. The internal muscles of the eye—in accommodation. 2, The external muscles

especially of the recti interni in convergence. 3. The light perceptive apparatus—the retina. 4. The conjunctiva by the heat rays. The varieties of asthenopia due to these causes are known separately as accommodative, convergent, retinal and conjunctival.

The first and second are easily understood, and the fourth also, as we all know that by prolonged eye work with artificial light hyperæmia of the conjunctiva rapidly ensues. About the third variety there is some difference of opinion. If we gaze at one point on a printed sheet for a long time, we notice that the black type gradually gets indistinct and cloudy ; this points to tiring of the retina, and is a subjective phenomenon. The question remains, can we find a qualitative and quantitative objective expression of the wearying of the eye.

The recovery of the tired retina is rapidly effected by the lid closure, the eye movements and accommodative changes. Each of these factors helps to clear up the type in the above example, and all together make it completely clear. The last two factors work unceasingly in reading, but the lid closure only from time to time. Katz has observed that not only wearying of the retina, but also of the accommodation and convergence result in an increased frequency of the lid drop, and hence the tiring of the eye is evidenced by the frequency of the lid closure. By a series of exact experiments in the physiological laboratory in the St. Petersburg University, gained the following interesting results :

1. Electric light (Edison's incandescent lamp hidden from the eye by a metallic reflector). The book lighted with a 10 to 12 candle-power for 10 minutes at a distance of 30 cm. from the eye. During the first five minutes there were five blinks, whilst during the second five minutes thirteen blinks. The frequency of the blink in the minute $\frac{5+13}{10} = 1.8$.

2. Gas light (open flame); other details same as in the first experiment. In the first five minutes 9 winks, in the second 19. $\frac{9+19}{10} = 2.8$ per minute.

3. Weak light (so that one could read with an effort at 16 to 18 cm.) First five minutes 25 blinks, second five minutes 43. $\frac{25+43}{10} = 6.8$ per minute.

Amblyopia from Acetanilid.

HIBBERT, R. "Case of amblyopia from use of acetanilid."—*Memorabilien.* XXXIX. Heft. 2.

A man of 36 years after a night of dissipation took one gramme of acetanilid to clear his head, and feeling no relief took a second gramme.

in an hour. The headache was relieved, but vertigo ensued, with loud rushing noise in ears and subjective olfactory disturbances Vision in both eyes rapidly failed. The face was pale, pupils were semi-dilated and did not react to light, and he could barely recognize hand movements at one-half metre. The fundus was pale and its vessels contracted. Pulse 64.

Under inhalations of amyl nitrite and doses of brandy every two hours the patient in the course of eight hours regained his vision, and by noon next day vision was fully normal and the field free.

Evidently the cause was anæmia of the retina and possibly of the visual centres. *J. W. Stirling.*

Canadian Medical Literature.

[The editors will be glad to receive any reprints, monographs, etc., by Canadian writers, on medical or allied subjects (including Canadian work published in other countries) for notice in this department of the JOURNAL.]

PERIODICALS.

AUGUST, 1895.

CANADIAN MEDICAL REVIEW.

Treatment of tumours of the bladder—F. Grasett, Toronto, p. 43.
Case of hypertrophic muscular paralysis, J. T. Fotheringham, Toronto, p. 45.
Notes on the Medical Military Service—G. S. Ryerson, Toronto, p. 47.

THE CANADIAN MEDICAL RECORD.

The present status of the electrical treatment of fibroids—A. Lapthorn Smith, Montreal, p. 244.

SEPTEMBER, 1895.

THE CANADIAN PRACTITIONER.

Treatment of pulmonary tuberculosis—Delaski Marr, Ridgetown, Ont., p. 639.
Indications for electrolysis in angeioma and goitre—C. R. Dickson, Toronto, p. 644.

THE CANADA LANCET.

The economics of prostitution—Woods Hutchinson, Des Moines, Iowa, p. 1.
How vaginal douches sometimes cause severe accidents—Donald B. Fraser, Stratford, Ont., p. 10.
Preferable method of sterilization and storage of catgut—J. Coplin Stinson, Hamilton, Ont., p. 11.

THE MARITIME MEDICAL NEWS.

President's Address, Canadian Medical Association—Wm. Bayard, St. John, N.B., p. 183.
Blindness from ophthalmia neonatorum—J. G. Nugent, p. 192.

LA CLINIQUE.

De l'alimentation des enfants—Paul E. Prevost, Montreal, p. 43.
La digitale—S. Z. Gauthier, St. Ephrem d'Upton, P.Q., p. 48.

MEDICAL NEWS, SEPT. 28TH.

Tongue traction as a cardiac stimulant—H. A. McCallum, London, Ont., p. 345.

ARCHIVES OF PEDIATRICS.

Some forms of eruption simulating scarlatina—A. D. Blackader, Montreal.

DOMINION DENTAL JOURNAL.

Epulis—A. H. Beers, Cookshire, Que., p. 244.

NORTH CAROLINA MEDICAL NEWS.

Have we any medical facts?—John R. Hamilton, Port Dover, Ont., p. 145.

The Treatment of Tumours of the Bladder.

In this paper two cases are recorded, the first, a woman aged 48, had been passing blood, supposed by her to be an alteration in the menstrual flow, for nine months. When seen she was extremely weak from the loss of blood. The bladder was opened through the

anterior vaginal wall and a small growth removed by the finger-nail and forceps from the lower and back part of the bladder wall in the vicinity of the right ureter. No sutures were put into the bladder and the patient made an excellent recovery.

The second case, a farmer aged 60, had suffered for nine years from periodical attacks of severe hæmaturia, but without pain until recently. Supra-pubic cystotomy was performed and a soft growth about the size of a small apple removed. Hæmorrhage was severe. Progress was good for a time, when perineal cystotomy had to be performed. The nature of the growth is not given in either case.

A Case of Pseudo-hypertrophic Muscular Paralysis.

This case, an Englishman aged 27, shows plainly the intermission in the progress of the disease. He was at his worst till puberty and then for eight or nine years was able to lead a fairly active life. His body is fairly healthy, except with referrence to the nervous system. There is disorder of the power of motion only, sensation being undisturbed. The calves of the legs measure an inch more than the thighs, the muscles in the latter region being atrophied. The gluteal muscles are small and soft, the prominence of the lumbar muscles exaggerated, and the curve of the lumbar vertebræ, if anything, a little too marked. Hypertrophy of the infraspinati and deltoids wanting. The mental powers are unimpaired. Reaction of degeneration is not seen, but the patellar tendon reflex is quite abolished on both sides. There is no ankle clonus. He cannot rise from a chair without using his arms, and on sitting down drops into the chair suddenly. The attempt to rise from the kneeling position is the characteristic one of "climbing up upon his legs." He is the seventh child of thirteen; two brothers are similarly affected, the eldest aged 40, very much worse, and the youngest, aged 20, much less than he is. Father dead, was intemperate; mother living and in fair health.

Blindness from Ophthalmia Neonatorum.

This paper is an elaborate statement of the statistics of blindness in Canada, and the author points out that in a very large percentage this condition is due to ophthalmia neonatorum. He strongly advises circulating a public warning against this disease, and that legislative steps should be taken in this country, as in England and in some parts of the United States, to endeavour to stamp it out.

Tongue Traction as a Cardiac Stimulant.

In June, 1892, Dr. J. A. Mullin, of Hamilton, in a discussion on chloroform before the Ontario Medical Association, said that he regarded forcible pulling on the tongue several times as the most power-

ful excitor of respiration. This was some time before Laborde, of Paris, recommended "rhythmic tongue traction" in asphyxia. The author, making use of the suggestion, resorted to the manipulation in anæsthetic accidents with animals used in physiological demonstrations. A number of dogs, cats, and rabbits were anæsthetized and experimented upon and it was soon determined that tongue traction is a powerful cardiac stimulant. The author is led to conclude that its mode of action is on the cardio-accelerating centre in the medulla, and he is satisfied that in restoring cases of asphyxia, it will succeed, when all other methods fail, because it acts, as both a respiratory and cardiac stimulant. It could and should be combined with some good method of artificial respiration in anæsthetic accidents, asphyxia or syncope from any cause.

Some Forms of Eruption Simulating Scarlatina.

In this paper, read at the meeting of the American Pediatric Society, the writer states that the presence of a scarlatinal rash, going on to desquamation and associated with pyrexia does not of itself warrant the diagnosis of scarlatina; not even although it should present a certain amount of superficial tonsillitis. Cases will arise where an absolute diagnosis is impossible until some days have elapsed, and the physician should be extremely cautious less he too rashly condemns a child to quarantine and the family to all the suspense and worry connected with such a proceeding. Among the simplest of the scarlatiniform rashes that may lead to possibility of error in diagnosis, are the erythemata resulting from the administration of certain drugs. Of these the rash produced by belladonna is well-known. Salicylic acid and its compounds are more frequently credited with producing an urticarial rash than a scarlatiniform erythema, but a case is here reported where a rash of that nature was produced. The rashes of phenacetin and phenazone are usually patchy in character, but cases may occur which give rise for some hours to the fear lest they should prove to be scarlatina. Copaiba, oil of turpentine, iodoform and many other drugs are also reported to have produced such a rash.

Allied to the rashes produced by drugs are the transitory eruptions due to the accidental absorption of toxines from the alimentary canal or elsewhere, and the rashes following the use of enemata. Transitory erythematous blushes or distinct rashes are occasionally seen in cases of tonsillitis and diphtheria; and in septicæmic conditions in children. Cases of erythema roseola may become distinctly scarlatiniform, but the rash is transitory and is not uniform over the whole body, the throat is also quite free. Acute desquamative dermatitis is another condition which may lead to error. The most important of the rashes

simulating scarlatina are met with sometimes in epidermics of rubella or rotheln. In general the rash in this disease resembles measles rather than scarlatina, but there are cases where the rash is distinctly scarlatiniform, and where an important factor for correct diagnosis is time.

The points which should influence us in making a diagnosis are that in rubella there is much less disturbance of the nervous system, the rash on the lower extremities shows a distinctly patchy condition, with well defined or slightly raised margins, or some times assumes an almost morbilliform appearance, which is never the case in scarlatina. There is but slight congestion of the throat and the cervical glands are almost invariably enlarged early. The well-known "strawberry tongue" of scarlet fever is not seen. In all such cases absolute isolation should be insisted on until such time as a positive diagnosis can be expressed. *Kenneth Cameron.*

Reviews and Notices of Books.

The Urine in Health and Disease and Urinary Analysis. By D. Campbell Black, M.D., L.R.C.S., Edin., etc. Philadelphia: Lea Brothers & Co. 1895.

Another publication is added, under the above title, to the rapidly increasing number of guides to microscopical and chemical medicine considered from a clinical standpoint.

Following upon the lines of the German text-books, Dr. Black has compiled a very useful and well classified volume of interest, not only to students and practitioners, but also to those engaged in special researches.

Introductory chapters deal with anatomical and physiological considerations in some detail. The various tests are well arranged and explained in a readable form; in addition useful plates and tables are appended.

A serviceable chapter is devoted to the elementary examination of urinary calculi.

It is regrettable that so little space is allotted to the bacteriological examination of urine, to which the writer gives but a passing reference.

The polariscopic method of the quantitative estimation of sugar, although in high favour in nearly all the European clinical laboratories, is not explained, while occasionally further details might be desired in some of the more elaborate tests.

In general, however, it is but fair to say that the author has well succeeded in his aim at "conciseness, and the treatment of the subject from the practical and clinical standpoint." C.F.M.

Disorders of the Male Sexual Organs. By Eugene Fuller, M.D., Instructor in Genito-Urinary and Venereal Diseases in New York Post-Graduate Medical School, etc.; pp. 241. Philadelphia: Lea Brothers & Co. 1895.

We regret that this work should have been given such a misleading title, for it leads one to expect too much from it. It deals with only one part of the male sexual organs, namely, the seminal vesicles. It gives the anatomy, physiology and pathology of the vesicles, while a chapter is devoted to the prognosis and treatment of the inflammatory diseases which affect this part. A number of cases are quoted at the end of the book, with a view of illustrating the various points touched upon in the body of the volume.

The work is illustrated by a number of plates which are reproductions of photographs of dissection, but we think it would be better if they were drawn in a more diagrammitic manner, as they would then gain in clearness what they lost in artistic value.

The proof-reading is a little careless, as for instance, on page 90, we notice shoeback for horseback.

Still the work is an excellent one on a subject which has not, as yet, received much attention, and a perusal of it will reveal reasons why some cases of gonorrhœa are so difficult to cure.

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Perforation in Enteric Fever; Its Surgical Treatment. By Frederick Holme Wiggin, M.D., Visiting Surgeon New York City Hospital (B.I.), etc. Reprinted from Proceedings of the Connecticut Medical Society. 1895.

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Strabismus as a Symptom, Its Causes and Its Practical Management. By Leartus Connor, M.D., Detroit, Mich. Reprinted from the *Journal of the American Medical Association*, June 28, 1895.

Cystic Tumors of the Vaginal Vault, with Reports of Two Cases. By Frederick Holme Wiggin, M.D., Visiting Surgeon to the New York City Hospital (B.I.), Gynæcological Division, etc. Reprinted from *New York Medical Journal* for July 13, 1895.

Medical Terminology its Etymology and Errors. By P. J. McCourt, M.D., New York. Reprinted from the *Medical Record*, July 27, 1895.

The Study of Anatomy. By D. J. Gibb Wishart, B.A., (Tor.), M.D.C.M., L.R.C.P., Eng. Reprinted from the *Canada Lancet*, October, 1805.

Narcotic Addiction. By Stephen Lett, M.D., Medical Superintendent of The Homewood Retreat, Guelph, Ont. Reprinted from the *Canadian Medical Review*, Toronto, July, 1895.

The New Sanitary Division of the Weather Bureau. By Hon. Mark W. Harrington, Chief. Reprinted from *The Health, Sanitation and Climatology of the Southern States* (Washington, D.C.), for April, 1895.

Circular No. 4. Climatology. Information relative to the investigation of the influence of climate on health.

Circular on the Care and Disposition of Persons Found Unconscious on the Streets or Elsewhere. Prepared by a special committee of the Medical Society of the County of Kings, N.Y. Reprinted from the *Brooklyn Medical Journal*, June, 1893.

Paroxysmal Sneezing. By W. Scott Renner, M.D., C.M., Buffalo, N.Y. Reprinted from *Buffalo Medical Journal*, August, 1895.

Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Annual Meeting.

The twenty-fifth annual meeting was held on Friday evening October 4th, 1895.

Dr. G. P. Girdwood, President, in the chair.

There were present: Drs. J. G. Adami, D. B. Alexander, J. H. B. Allan, T. J. Alloway, G. E. Armstrong, G. A. Berwick, A. D. Blackader, E H. P. Blackader, G. A. Brown, F. Buller, J. C. Cameron, K. Cameron, G. G. Campbell, F. R. England, D. J. Evans, J. J. Gardner, W. Gardner, G. P. Girdwood, N. D. Gunn, D. F. Gurd, H. D. Hamilton, W. F. Hamilton, J. Alex. Hutchison, J. M. Jack, R. C. Kirkpatrick, H. A. Lafleur, F. A. L. Lockhart, C. F. Martin, W. Mills, J. A. Macphail, J. B. McConnell, R. T. McKenzie, J. Perrigo, A. Proudfoot, T. D. Reed, T. G. Roddick, G. T. Ross, F. J. Shepherd, A. L. Smith, J. Stewart, J. W. Stirling, W. J. Telfer, A. S. Wade, G. Wilkins, and C. F. Wylde; forty-five in all.

The minutes of the last annual meeting were read and confirmed.

Report of the Treasurer.

Dr. J. M. JACK, Treasurer, read the report, which showed the receipts to have been $609.26, and the expenditure $672.45 for the year. There was a cash balance of $155.25 in the bank. The assets were estimated at $684.25 and liabilities at $72.49.

Report of the Secretary.

Dr. G. GORDON CAMPBELL, Secretary, reported that the session had commenced with 130 members; 13 new members were elected, 3 died, 3 resigned, and 18 had been removed from the roll, making the present membership 119. There were besides 20 temporary members.

The attendance showed a marked improvement, the average of 33.25 of the previous session increased to 40.3, an increase of 7. There were 19 regular meetings and the smallest number present at any meeting was 18 and the largest 63.

Report of the Librarian.

Dr. F. A. L. LOCKHART, Librarian, stated that he found it impossible to keep the library in proper order while there were so many unbound journals lying about and such a small amount of shelf space. He expressed the hope that some one would come forward and offer

to bind those journals which were of value, as the Society was unable to do so. The journals on file, for the same reason, had been reduced to three, *The Lancet*, *The Medical News*, and the *American Journal of the Medical Sciences*.

The following donations of Medical Literature had been received:

1. Miscellaneous journals left anonymously in the library.

2. *Robert's History and Practice of Medicine*, donated by Dr. F. W. Campbell.

3. Complete volumes, unbound, of *British Medical Journal*, 1891, Vol. II., 1892, Vol. I.; *Lancet*, 1891, Vols. I. and II., 1892, Vols. I. and II.; *New York Medical Journal*, 1891, Vols. I and II., 1892, Vols. I. and II.. *American Journal of Obstetrics*, 1891 and 1894; *Medical Record*, 1891 and 1894; *Medical News*, 1891, Vol. I. and II.; incomplete volumes of various medical journals; donated by Dr. A. D. Blackader.

The incomplete volumes had been useful in supplying missing numbers in other series of journals.

Dr. T. G. RODDICK having asked of the librarian the probable cost of binding the volumes mentioned, kindly donated the twenty dollars considered sufficient for that purpose.

The following officers were elected for the session 1895-96:

President—Dr. A. D. BLACKADER.
1st Vice-President—Dr. F. G. FINLEY.
2nd Vice-President—Dr. J. W. STIRLING.
Secretary—Dr. G. GORDON CAMPBELL.
Treasurer—Dr. J. M. JACK.
Librarian—Dr. F. A. L. LOCKHART.
Council—Drs. G. P. GIRDWOOD, J. G. ADAMI and G. E. ARMSTRONG.

Annual Address of the Retiring President.

Dr. G. P. GIRDWOOD delivered the annual address as follows:—The proceedings in which you have just taken part warn me that another year has completed its course and it becomes my duty to read the annual address. I have to carry my thoughts back to a year ago when you honoured me by electing me to preside at our meetings, and, gentlemen, before I briefly review the work that has been done in the Society, permit me to thank you, not only for the honour you conferred upon me at that time, but also for the kindly courtesy which I have received from one and all, for assistance so often required, always so cheerfully given, which has enabled me to conduct the the business of the Society with, I trust, satisfaction and benefit to

all interested. But, gentlemen, although I have to thank every member of the Society, I must especially return thanks to the other officers of the Society, who have so largely contributed to the result—the energetic Secretary, the careful custodian of our funds, and the members of the council, one and all.

On looking back over the records of the past twelve months I find that death has been busy amongst our numbers, and we have to deplore the loss of three of our younger associates. Dr. E. A. McGannon, of Brockville, one of our country members, who from his distant residence was not often able to come to our meetings, but always kept us in mind, and forwarded us such subjects and notes of cases of interest as came in his way. Dr. E. E. Duquet, who had devoted himself to the care of those unfortunates who from some cause had lost their reason and become insane, a class of the community whose misfortune appeals to our care and requires the utmost watchfulness and the highest qualities of mind and education on the part of the physician. And Dr. E. P. Williams, who was associated with the teaching staff of McGill College, where he was making a name for himself by his devotion to his profession and especially to its pathological department, who lost his life by accidental blood poisoning whilst fulfilling the duties required of him in the alleviation of human suffering; a young man of bright promise who had endeared himself to those associated with him by his earnest work and his many sterling qualities. Gentlemen, we mourn their loss.

The number on our roll now stands as follows:

Number last year		130
Loss by death	3	
Loss by resignation	3	
Loss by writing off	18	
	—	24
Additions in new members		13
Making a total loss of		11
Our number remaining		119

Our financial statement our Treasurer has read to us. I would that the outlook were brighter, but by putting our shoulders to the wheel and by paying in our subscriptions at the time they are due, we shall keep the Treasurer in funds and be able to carry on any work that may be needed.

We have had 19 meetings with an average attendance of 40.3, an increase of average of 7 over last year; our largest attendance 63, smallest 18. We have had brought before us in all 88 subjects of interest by 38 members, a very good measure of success. Of these,

living cases 16, pathological specimens 40, case reports 13, papers 16 discussions 3. These papers, etc., may be further divided into:

	Medicine.	Surgery.	Obstetrics.	Gynecology.	Pediatrics.	Dermatology.	Anæsthetics.	Ophthalmology.	Laryngology.	Anatomy.	Physiology.	
Living cases	..	12	..	..	..	1	..	..	..	1	2	=16
Pathological specimens	17	9	2	8	..	..	..	1	..	2	1	=40
Case reports	5	2	1	..	..	1	2	..	..	..	2	=13
Papers	3	4	1	1	3	1	2	..	1	..	..	=16
Discussions	1	1	1	..	..	..	..	..	..	..	..	= 3
	26	28	5	9	3	3	4	1	1	3	5	

We have had amongst these, highly interesting case reports and pathological specimens and results of recent surgical methods and appliances, physiological experimental work, observations of numerous similar cases collected together and the results tabulated, a number of papers, and cases of great interest to those whose time is occupied in general practice, as well as to the specialist in each branch.

The prominent feature of the year was the introduction of the practice, suggested by Drs. J. C. Cameron and J. Bell, of setting apart special nights on which some subject of general interest to the Society has been introduced by three members and a subsequent discussion taken part in by the members generally. This practice, I think, has been so much appreciated by the members as to commend itself to them for future and further extension. I must congratulate the Society on the number of younger members who have brought before us their experience and ideas.

Amongst the subjects to which the Society has directed public attention, one was the practice of spitting about in public places and public vehicles. In this connection a representation was made to the management of the Street Railway Company, to which representation a courteous reply was received, and I see that notices are placed in all the cars against the practice. Upon this subject I think a more energetic protest may be made, and a more public one. I think we might induce the Board of Health to obtain the assistance of the School Boards and teachers to inculcate the dirtiness, uselessness and danger to health of this habit, whereby micro-organisms or dirt in which they may grow are distributed broadcast, and thus encourage

early development of cleanly habits and educate the young to a more cleanly and therefore more healthy life than their predecessors.

The Society this year sent a deputation to call the attention of the Harbour Commissioners and engineers connected with the harbour improvements to the probable source of danger to the health of the citizens by the emptying of the city drains into the slack water basin at present under construction. The attention of the Board of Health was also called to the same question by the Society, and representations made by that body to the authorities.

I think, gentlemen, that our Society ought to have, as my late predecessor has said, a permanent resting place and a home of its own. He pointed out the possibility of some well-disposed and wealthy citizen aiding in the erection of some permanent home. If this should be carried out I think it will be the result of the Society performing public duties by calling the attention of the general public to those steps and to such regulations as will help on public sanitation, and thus bring about a more healthy condition of city and dwellings, and in the end lead to a monetary value in the reduction of the rate of life insurance, or its equivalent, the addition of larger profits on the policy. If we could show an increased longevity as the result of our efforts, I think there would soon be a generous outpouring by the recipients to those who had been the cause.

And then it would be possible for this Society to supply a well-equipped work-room, where the members who are not connected with teaching bodies could be supplied with every convenience for original research and private rooms to work in, as in the Medical Society of Edinburgh.

The Late Dr. E. P. Williams.

The following resolution was passed :

That the President and members of the Montreal Medico-Chirurgical Society herewith tender to Mrs. Williams their sincere commiseration with her in the great loss that she has sustained in the untimely death of her only son, Dr. Edward Parmlee Williams. As a member of this Society, Dr. Williams had shown himself a keen and enthusiastic worker. As Demonstrator of Pathology and Assistant Curator of the Museum at McGill University, and as Assistant Pathologist at the Montreal General Hospital, he had made abundant use of the opportunities presented to him and had been most active in bringing before the Society the results of his investigations. In his frequent publications before this Society he had not simply given promise of future distinction, but, young as he was, had brought before it results of researches which are of abiding interest.

Warm-hearted as a friend, as a comrade always bright and inspiring, and never sparing of himself in the exercise of his profession, this Society mourns his loss, and deplores that he should have been removed from its ranks and from the service of his profession at a time when the enthusiastic work of years was at last beginning to bear fruit. It begs with all respect to convey its sympathy to his widowed mother in her irreparable loss, and to his sister left thus suddenly brotherless.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.

AT ITS NINETEENTH ANNUAL MEETING.

Montreal, September 17, 18 and 19, 1895.

[REPORTED BY C. W. ALLEN, M.D., SECRETARY.]

A very successful meeting of this body of specialists was held at the Windsor Hotel, and during the sessions, extending over three days, papers were read by well-known men from various cities in the United States and our own country. It is a matter of satisfaction to us to note that in a social way the meeting was also pronounced a success, and at the last session, held at the Montreal General Hospital, where a clinic was conducted by Dr. Shepherd, a vote of thanks from the members was extended to the gentlemen of Montreal for their highly appreciated attentions.

Address of the President.

Dr. SAMUEL SHERWELL, of Brooklyn, N. Y., welcomed the members present in an address in which he predicted a successful meeting and congratulated them on the fulness of the programme and promised quality of the papers. The chief topic discussed was the preponderance of the alien element in those seeking relief for skin troubles in the public institutions. Interesting statistics bearing upon this question were presented.

The limitations of the microscope in dermatological work was then taken up, and after showing the necessity for clinical investigations in solving many problems, suggestions were made as to the future work of the Association along certain lines of high scientific interest. Constitutional treatment is considered by the speaker necessary in most skin cases, but he would by no means have it employed to the exclusion of local measures; the two must go hand in hand.

The first paper was presented by Dr. FORDYCE, of New York, and included three subjects:

Angiokeratoma of the Scrotum—Raynaud's Disease of the Ears—Lupus Erythematosus Disseminatus.

The lesions of the first case occurred upon the scrotum of a sixty-year-old man and consisted in a large number of dark purple tumours from a pin-head size up, some covered with a somewhat thickened horny layer of epidermis. There appeared to be lacunar spaces filled with blood occupying the papillary portion of the derma. The reader upheld Pringle's opinion that the blood spaces in the rete are caused

by a downward growth of the cells of the layer, causing constriction of the terminal loops and resulting distention. Histologically the author's case agreed with the description of those previously observed.

A linear arrangement of the lesions seemed to follow the course of the vessels of the part. The horny layer of the scrotum being naturally thinner than that of the hands the hypertrophy reached a lesser degree than in the latter case.

Dr. ZEISLER said the case he had reported corresponded to the type described by Mabelli, but differed from this, still he thought the descriptions of the disease might not yet be complete, and additional features might be presented in other cases. He thinks it not unlikely that the scrotum may occasionally be the seat of the affection in the presence of varicocele. He thought great enlargement of the horny layer an essential feature of the disease. In his case it was five or six times as thick as in this one. Keratoma should be marked to make the term angiokeratoma appropriate.

Dr. SHEPHERD had seen many instances of varicosity of the scrotum and in a large proportion there was great vascularity of the skin. He considered the condition a varix.

The subject of the second paper was a man of thirty-nine, presumably syphilitic, whose ears would become suddenly blue and cold, remaining so for several hours. This was followed by gangrene and subsequent cicatrix. Attacks recurred at intervals, and finally a permanent bluish-black discoloration remained as a lasting condition. Syphilis is advanced as a cause. The arterial coats are implicated leading to obstruction in the blood supply, when spasm of the vessel due to cold or other cause is superadded.

Dr. WHITE had observed a case in which the ears were coincidently affected along with the finger tips. He saw no reason for precluding Raynaud's disease on account of the location.

Dr. SHERWELL thought most instances of Raynaud's disease occurred in syphilitics. He had seen a typical case recover under antisyphilitic treatment.

Dr. FORDYCE said that in many of Raynaud's own cases the extremities were free. The term is a general one, including endarteritis, and many other pathological conditions.

In the third paper lupus erythematosus was described as occurring in two women, and disappearing spontaneously during pregnancy.

Dr. HYDE thought we must enlarge the conditions to which we apply the term lupus erythematosus. In one case the lesion of lupus erythematous upon a woman's cheeks disappeared under very simple treatment, and almost immediately a typical lichen planus developed upon the extremities.

The next paper was read by Dr. GRAHAM, of Toronto, upon

Hydroa Æstivale.

with a report of two cases of this rare condition, supposed to be due to sunlight. In the first, a few small, red spots appeared upon the face and hands of a young girl. These recurred as soon as she began to go out of the house; afterwards the lesions became vesicular and pustular, and later became black in the centre and umbilicated, followed by crusting and subsequent scarring. No spots appeared on the hands when gloves were worn. The second case was a blonde who suffered from burning sensations, swelling, and vesicular eruptions when exposed for twenty minutes or more to the sun's direct rays. Malaise, coryza, sleeplessness, and anorexia accompanied the attacks. In this case, sitting near an open window produced the eruption on any exposed part of the body. On account of the affection the patient has been virtually a prisoner in the house for fourteen years. The skin is at times fissured and scaly as in a chronic eczema.

Dr. GRAHAM believes that it is not only the ultra-violet rays, but also the heat rays of the sun which play a part in producing the affection. It is hard to explain without the intervention of the vaso-motor nerves how they produce such an effect. These rays seem capable of producing a dermatitis of variable intensity. The amount of necrosis and subsequent cicatrization will depend upon the vulnerability of the tissues and the amount of exposure. Unlike xeroderma pigmentosum, it does not seem to attack more than one member of a family. A covering to the skin which would exclude the light, he said, was almost always effectual.

Dr. ZEISLER spoke of a case he had observed. He thought the condition one of erythema multiforme and suggested atropine as a remedy.

Dr. WHITE would look upon it as a dermatitis rather than as a separate affection to which a particular designation was applicable. No absolute type of lesion is maintained in all attacks.

Dr. BOWEN had examined one such case histologically; the inflammation was here followed by necrosis; the lesions were umbilicated. The microscope showed that the necrosis extended down to the corium. This distinguishes it from erythema multiforme, which is never followed by scarring.

Dr. HARTZELL had seen a case in warm weather where the lesions came in the absence of exposure to direct sunlight. The inflammation was not severe enough to produce necrosis. It differed from other cases only in the degree of inflammation.

Dr. PHILLIPS, of Toronto, had treated the patient described in Dr. Graham's paper, and on invitation spoke of his treatment, which had

been mainly soothing and protective. He thought the ultra-violet rays of light those which produced the effect. He had intended to try their exclusion by covering the parts with bisulphate of quinine in bassorin paste, or to cover the face with some yellow-coloured material.

Dr. JACKSON had had for several years a boy under his care who presented lesions, pittings, and scars of the same affection. He suffered more in winter than summer. This was also the case in Alp-climbers, he believed, in whom an English physician (Bowles) had made a successful use of such a brown ointment as actors use.

Dr. SHEPHERD had within two weeks seen a young lady in Montreal with a dermatitis of three years duration, which would appear on exposure out of doors, accompanied by swelling, bullous lesions, and followed by scarring. He had seen it appear in a fellow-traveller in crossing the Alps.

Dr. ALLEN remembered Dr. Jackson's case, and having frequently seen the boy, could substantiate the fact of the eruption being at times severe in the winter. From his readings he came to believe the chemical rays responsible, and considered exclusion of light the only rational treatment.

Dr. SHERWELL recommended that women so predisposed should always wear yellow veils, and that by so wrapping up the head as to make a virtual developing chamber the disease would be prevented.

Dr. GRAHAM, in closing, said Dr. Bowen's investigations would exclude any idea of the condition being an erythema. He thought the degree of inflammation depended upon the individual rather than upon the length of exposure. *Dermatitis solaris* would, all things being considered, probably be the most appropriate name.

Two Cases of Bromide Eruption

was the title of the next paper, by Dr. JACKSON, of New York, who described a chicken-pox-like eruption beginning on the face and spreading over the body in a young woman who had been shortly before taking the bromide of potassium. Crusts formed and under these a raspberry-like form of elevated lesion which bled easily and upon the legs broke down into indolent ulcers.

The second case, in a child, showed the same raised warty growths covering whole regions of the body.

Dr. HYDE thought pronounced types and aggravated forms of bromide eruptions were seen chiefly in broken-down subjects or in cachectic children.

Dr. MORROW thought any eruption which does not correspond to the classical type of ordinary dermatoses should suggest drug etiology.

Dr. WHITE thought the effect wholly one of individual idiosyncrasy. He had seen a healthy nursing infant affected through the mother's milk.

Dr. HARTZELL thought there was a connection between imperfect circulation, as in heart disease, and the occurrence of the eruption.

Dr. FOX said Dr. Jackson's case at one time resembled hereditary syphilis. The diagnosis would be difficult, in a syphilitic child who was taking bromide.

Dr. GRAHAM spoke of the difficulties in instances in which the bromides were given without the physician's knowledge, or in which no history of administration could be obtained.

Dr. ALLEN had seen iodide eruptions closely simulating such fungating lesions as those described. Bromide eruption may appear and persist long after the drug has been stopped. He would accuse nerve effect rather than cutaneous elimination.

Dr. SHERWELL had also seen cases where drug administration was denied, as well as instances from the iodides which were clinically identical with those from bromides.

Dr. JACKSON had since writing his paper seen an epileptic in whom the eruption kept coming out for some weeks after the bromide was stopped.

The next paper was by Dr. BOWEN, of Boston, and was entitled

The Epitrichial Layer of the Epidermis and Its Relationship to Ichthyosis Congenita.

In certain lower animals there is a well-marked layer of cells in the epiderm of embryos, forming a distinct membrane covering the hairs. In man this layer has not received recognition. The reader's attention had been directed to the subject by the observation of Dr. C. S. Minot that certain shreds of fœtal skin contained a layer of large polygonal cells, with a granular body in the centre, and within this a nucleolus. He thought these cells a part of the epitrichial layer described by Welcker in 1864, and since forgotten.

The reader of the paper has found that in embryos of from two to three months the epidermis has an outermost layer of large nucleated polygonal cells of peculiar shape. In the sixth month this layer has disappeared over most of the body. The resemblance of this layer of cells to the epitrichium covering the hairs and the epitrichial layer of certain animals makes the author conclude that they are homologous structures.

A case was related of a child born with a thin, perfectly smooth membrane completely covering it and closely adherent. This began to peel off after five weeks in large strips, leaving normal-looking

skin. There were no fissures as in ichthyosis. This condition seemed to be due to the persistence of the epitrichial layer, and the author believes that similar cases reported by Hallopeau, Grass and Török belong to the same category. Instead of gradually exfoliating and disappearing by the seventh fœtal month the epitrichial layer retains its integrity.

Dr. SHEPHERD, of Montreal, then read a paper based upon

A Remarkable Case of Purpuric Eruption Ending in Gangrene and Apparently Caused by Sodium Salicylate.

A patient in the Montreal General Hospital suffering from acute synovitis, was given three twenty-grain doses of salicylate of sodium when an urticaria-like eruption appeared and soon became petechial. These lesions were followed by deep sloughing, leaving ulcerations slow to heal. The upper portion of the body, especially the region of the shoulders, was mostly affected. There was also an eruption in the pharynx and larynx leading to œdema and alarming symptoms. The eruption disappeared only after thirty days, in some cases passing through the various colour changes peculiar to extravasation. Local patches of gangrene occurred over the shoulders, etc., varying in size up to that of the palm. The patient showing extensive red cicatrices was presented at the meeting.

The general concensus of opinion in the discussion was that the eruption was due to the drug administered.

Dr. BRONSON thought it peliosis rheumatica modified by the salicylate.

Dr. SHEPHERD had never seen a case of peliosis rheumatica which went on to gangrene, but thought such a result might be a matter of intensity.

Dr. HYDE, of Chicago, then read a paper entitled

Does Mycetoma Occur in North America?

This contribution to the study of mycetoma of the foot was based upon the observation of a native of the United States, born of Bohemian parents who had never been outside of the country. It began at seven years, and had lasted thirteen. A hard nodule was first noticed in the skin of the sole, and gradually involved the anterior third of the foot. Fungoid irregular infiltrations were present, each tubercle being perforated by a central canal. They were made up of granulation tissue, with a considerable number of giant-cells in the derma.

The difference between the fungus of mycetoma and actinomycosis, is that the former grows much slower in an atmosphere of hydrogen and in the rapidity with which they take up aniline stain.

A constant symptom is a characteristic deformity of the affected part. There is a notable absence of pain. In a well marked case there is usually a central body, made up of semi-lunar or reniform bodies, traversed by a net-work of mycelium.

The clinical symptoms are: 1. The appearance of blackish or reddish granules of pigment, free, and within the cells furnished by the secretion; (2) the discovery of particles resembling the roe of fish, either expelled from the sinuses, or imprisoned within the unbroken surface of the skin; (3) the occurrence of sinuses leading from without inward as far as muscle, tendon, or blood-vessel. Cases of unquestioned mycetoma are on record where none of these features are exhibited.

There are probably several varieties of the ray fungus. There may be an American variety.

Dr. WHITE, of Boston, entitled his paper

An Etiological Puzzle.

He described a tuberculosis of the skin of the hand in a young girl who had cared for a parent who had died of phthisis.

In a second case there were tuberculous lesions of the lobes of both ears developing after the operation of piercing. The friend who had bored the ears died soon after of phthisis. The puzzling point was to determine in what way infection had occurred. In discussion the various possibilities were reviewed without a positive solution being advanced.

Dr. HARTZELL, of Philadelphia, read a paper on

A Unique Case of Agminate Folliculitis of Parasitic Origin.

He described in a man of 32 years an oval elevated patch covered with scanty crusts, under which was a bright red, uneven granular surface. Close examination showed the patch made up of inflamed hair follicles. There were some small pustules. Primary pustules appeared at the periphery and increased the size of the patch. A small cavity surrounded the hair in the upper part of the epidermis, and a few spores and mycelial threads were found, occasionally grape-like clusters. The fingers presented larger elements than are usual in tinea circinata. After existing for ten months sulphur brought rapid cure. The case illustrates that trichophytosis may cause extensive painful disease in other locations than upon the hairy scalp. So far as he knew no case of this character in this situation had been previously reported.

Dr. HYDE spoke of severe trichophytosis in sheep shearers contracted from sheep, which took the form of sycosis.

Dr. FORDYCE presented a paper on

Drug Eruptions.

The nodular form of iodic eruption was described in a woman where the lesions reached the size of the fist upon a paralyzed limb, the vascular changes probably accounting for the exaggerated size.

Another case was that of a rupia-like eruption due to the iodide of potassium, but simulating syphilis, in a syphilitic subject. The lesions healed under boric acid ointment. A second case of similar nature showed ulcerations which healed when the iodides were stopped. The lesions in both cases corresponded with the anthracoid variety of iodide eruptions. The cases would seem to show that the skin in some persons reacts to iodide in much the same manner as to the syphilitic process.

An erythematous rash following the application of mercurial ointment was next described. Another case was a scarlatiniform erythema which had been mistaken for scarlatina. Another erythema resulted from the internal use of boric acid given in thirty grain doses. There was also present hard œdema of the eyelids.

Dr. JACKSON spoke of a case of supposed scarlatina which was really due to mercurial frictions.

Dr. MORROW, of New York, read a paper on

Urticaria Pigmentosa,

with the report of a case under his observation for twenty years, although the majority of cases show a tendency to disappear after eight or nine years. Factitious urticaria was a constant feature. Lesions resembling minute pigmentary nævi made their appearance as the preceding large nodules disappeared. In its clinical course and anatomical changes the affection differs in many points from urticaria perstans. At the present time it is impossible to say whether the urticarial elevations and pigmentations are expressions of the same or of different morbid processes, conjoined with vaso-motor hyper-excitability. There is probably some disturbance of the trophic centres which regulate nutrition.

Dr. BRONSON spoke of the localized character of the disease in urticaria pigmentosa in contradistinction to the haphazard character of the eruption in ordinary urticaria. The former shows a tendency to recur at certain distinct points.

Dr. BULKLEY thought the two conditions might be combined and that further microscopical study was required.

Dr. HYDE had seen three cases in Chicago, and this very case in New York many years ago. A distinction must be drawn between this and the ordinary form of urticaria, though at present it is expedient to consider them in the same category.

Dr. ALLEN had for several years past a case in his practice. There is an almost immediate eruption of wheals upon removing the clothing, and slight rubbing causes them to run together into large plaques implicating both pigmented spots and the intervening sound skin.

Dr. SHERWELL thought two distinct affections present. He related a case which had existed since early childhood.

Dr. MORROW said factitious attacks could be brought about by nervous excitement, by overheating, and by artificial means. The annullment of ordinary sensibility does not interfere with its development. It occurs equally upon anæsthetic areas.

Dr. ALLEN, of New York, read a paper upon

The Etiological Relation of Erysipelas to certain Lesions and its Treatment.

Fifty cases formed the basis for the remarks upon treatment, while one hundred instances had been studied in reference to preceding skin affection, or solution of continuity of tissue, as furnishing suitable condition for the penetration of the erysipelas germs. Fifty per cent. showed some such lesion.

Special stress was laid upon the adhesive bandage, tightly applied about the patch, as a means of checking the spread of erysipelas. It succeeded in nearly half the cases. Ichthyol in collodion was the best local dressing, and the reader's combined method of application, by covering in all the skin included between the straps was thought a most effective plan. Cases recovered within from one to several days. The straps are supposed to act by pressure upon the lymphatics.

Dr. CANTRELL, of Philadelphia, offered a contribution to

Ulerythema Sycosiforme,

in the preparation of which Dr. Schamberg had taken part. The writers describe a case of this affection to which Unna called attention under the above title in 1889. A man aged fifty-five had suffered in 1886 from a pustular disease of the beard lasting for two years and ending in recovery. In 1891 he again became affected with what seemed to be a non-parasitic sycosis. Two years later a smooth glistening area of atrophic appearance occupied portions of the cheeks, showing complete loss of hair in places. There were no pustules, but over the area were vesicles and blebs which dried into brownish crusts. The affection proved very obstinate, new vesicles appearing every few days. Arsenic aggravated the condition. In these cases a follicular and peri-follicular inflammation exists, which goes on to destruction of the hair-follicle and formation of atrophic scars. Histologically the stratum corneum and lucidum are missing; the

granulosum is well marked; sharply defined cell infiltration is seen, most marked around the hair follicles. We find overgrowth of connective tissue in the papillary layer; few hair follicles and no sebaceous glands are seen in section; and giant cells are absent. The disease simulates, but is not identical with, lupus vulgaris. There are no nodules and no bacilli. The writers agree with Unna in considering the condition a distinct entity and accept the name.

Dr. ROBINSON, of New York, then read a series of

Studies on Some Dermatological Subjects.

The first case spoken of was one of lymphangioma circumscriptum in a child of twelve years who had the disease from infancy. Coloured drawings showed the cicatrices from operations done at an early age, the spawn-like characters of the lesions, and the presence of blood in some of the vesicles. In a second instance of the same affection the pictures illustrated very extensive vesiculation and a number of blood-like cysts. The cysts were here smaller, the grouping less well-marked than in case one, and no scarring was present. In a third instance the patient was 27 years old. This had existed from birth, but new lesions had of late appeared. Some lesions appear clear, others as though filled with blood. The woman stated that at each menstrual epoch the lesions filled up and became quite red. There was never any associated dermatitis so far as known. In two of the cases the lesions had spread. Not much could be said for treatment.

A series of cases was then discussed with reference to the appropriateness of the names dysidrosis, pompholyx and cheiro-pompholyx. Some observers do not consider the disease as at all special, but as a form of eczema. The speaker was unable to see any resemblance whatever to eczema. Illustrations of an affection with vesicular and bullous lesions on palms and soles, always coming out simultaneously and in regular groups, were passed around. The lesions show the tendency to rupture. They pass away in a few weeks, but return after unusual exertion on the part of the patient. This all opposes a diagnosis of eczema. A second case, in a girl of twelve years, showed lesions of the same character appearing upon the palms and soles. The bullæ at first clear, become yellowish, and disappear after a time without sign of eczema or dermatitis. A picture of large bullæ upon the foot, the speaker thought, should be convincing that the disease was not eczema. The contents of the vesicles were invariably alkaline. Particular stress was laid upon this point because he had understood that Kaposi had of late years shown at his clinic, cases in which the vesicular fluid had an acid reaction, and referred to them as belonging to the class of cases which in America were called

dysidrosis or pompholyx. The microscope showed nothing to indicate a connection with the sweat glands. If there is no connection the term dysidrosis is faulty. He preferred cheiro-pompholyx.

Dr. ELLIOT thought there was no question that dysidrosis and pompholyx were distinct from eczema. He had seen a number of cases originating from exposure to heat, in persons of run-down constitution, or suffering from nervous prostration. The lesions are deep-seated, without signs of surrounding inflammation, resembling sago-grains, attended with a certain amount of itching, persisting for some time. They correspond in every particular with the lesions of hygrocystoma upon the face, and he could see no reason for considering them connected with the sweat glands here and not when they occur upon the palms and soles.

Dr. HARTZELL had observed that pain was a feature of these cases, rather than the itching and burning so characteristic of eczema.

Dr. BRONSON had found the fluid alkaline, while the sweat in the same locality was acid.

Dr. BULKLEY thought there was a nervous affection producing bullæ which differed from dysidrosis, still many cases of vesicular eczema of the palms, so closely resemble this condition that they are distinguished with difficulty.

Dr. KLOTZ was not disposed to lay too much stress upon the reaction of the bullous fluid, as there is some reason to believe that sweat, at first of acid reaction, becomes alkaline by remaining in the gland.

Dr. WHITE believed there were two affections of the hand, one undoubtedly dysidrosis, the other we might call eczema.

Dr. SHEPHERD thought pompholyx quite distinct from eczema in pathology and symptoms. He had seen a case in London which only occurred when the patient, an Australian, came to England. He had seen the condition in medical students from over-work and examination worry.

Dr, ROBINSON said it was only the grouped lesions which should be called pompholyx. In obstruction to sweat upon the face, there are no subjective sensations. The lesions of hygrocystoma of the face have acid contents, and there is absence of inflammation. In cheiro-pompholyx there is decided evidence of inflammation.

Dr. ELLIOT said the lesions he referred to were those described by Dr. Tilbury Fox as sago-grain vesicles. His question was, why Dr. Robinson proposed calling these sago-grain lesions occurring on the face hygrocystoma and connected with the sweat glands, but when occurring on the palms, cheiro-pompholyx, and having no connection with the sweat glands.

Dr. ROBINSON replied that the cases which Fox called dysidrosis, he called pompholyx. In reference to the similarity of the lesions between hygrocystoma and pompholyx, he could only repeat that if the lesions are grouped, symmetrical, not acuminate, confined to the palms or between the fingers, then they constituted the disease called dysidrosis by Fox, and which he proposed calling cheiro-pompholyx. If they are not such lesions then they are eczematous. In pompholyx the lesions disappear in about two weeks when the macerated cuticle exfoliates, leaving a tender surface behind.

Dr. ZEISLER said the situation in the palm might make the vesicles hard to rupture. He said the picture showing large bullæ was identical with Köbner's epidermolysis bullosa.

Dr. ELLIOT said the latter cases were always congenital. The secretions of pompholyx do not stiffen linen as those of eczema do.

Dr. ROBINSON then showed sections of the skin in a case in which the skin proper was normal but there was marked degeneration of the parenchymatous portion of the sweat gland, exactly similar to that seen in the kidney. He exhibited a sketch of the excretory duct, showing three albuminous casts in it. Albuminous and granular matters were observed in the coil as well as in the excretory duct. In cases of bromine and iodine rashes it might be well to study the condition of these glands, as he thought it likely they might be found to be the seat of the earliest stages of these lesions. The casts lying in the excretory duct, as shown in the sketch passed around, he considered unique.

Dr. ZEISLER, of Chicago, read a note on

Antiparasitic Treatment of Eczema,

pointing out that many of the well-known and tried remedies, such as salicylic and carbolic acids, thymol, tar, etc., were determined parasiticides. He then gave his personal experience in treating eczemas with strong antiparasitic drugs, which was decidedly favourable to such treatment without denying the value of constitutional, hygienic and dietetic measures. He had found Cutler's mixture of equal parts of iodine, carbolic acid and chloral of especial value. He advanced this as a type of remedy or combination which would be found of service. He also mentioned encouraging results from creoline.

In the discussion some speakers favoured the view that most eczemas are parasitic, while others could not accept this theory, claiming that micro-organisms are found in eczemas as upon the healthy skin without etiological significance.

Dr. WHITE said there was no evidence that eczema is ever a parasitic disease. Most reliance is to be placed in the older remedies.

Dr. BULKLEY thought there were two sides to the question. He becomes more and more convinced that there are local causes for eczema. We cannot exclude parasitism, because we cannot prove the parasite.

Dr. KLOTZ had found 50 per cent. watery solutions of ichthyol beneficial. He did not believe in ointments. A caustic potash solution to remove the *débris* is often necessary before remedies are applied.

Dr. WIGGLESWORTH thought proper constitutional treatment too much neglected. The general nutrition of the skin must be improved. He gave his patients minute instructions concerning everything that might bear upon the condition.

Dr. ROBINSON thought catarrhal dermatitis a more appropriate term until we can classify the conditions according to their causes. He thought most of them parasitic, but some were due to internal irritation. In diabetes and the uric acid diathesis internal treatment may cure an eczema, but that is no reason to exclude a parasitic local cause.

Dr. SHEPHERD thought most cases were due to micro-organisms. Internal treatment alters the conditions of the affected part and perhaps makes them less vulnerable, so that what produces an eczema at one time will not at another.

Dr. GRAHAM spoke of eczemas arising from internal causes, and instanced a universal eczema with hepatic symptoms and a gall-bladder filled with gall-stones. In another case the liver was found studded with tubercles and in a state of fatty degeneration.

Dr. SHERWELL favoured constitutional, but used also local treatment.

Dr. ZEISLER thought a new era was dawning in the treatment of eczema. The parasitic theory had many able supporters. A combination of drugs often seems to act better than single remedies. He could not grasp the connection between dieting and the cure of severe local inflammation.

Dr. ELLIOT, of New York, read a paper on

A Further Study of Alopecia Præsenilis or Præmatura and Its Most Frequent Cause.

Heredity, he said, plays a small part in producing early alopecia. Only four incontestable instances were found in over three hundred cases treated. Over 90 per cent. are due to the one disease, eczema seborrhœicum. There was included in the paper read a preliminary report upon the bacteriology of seborrhœal eczema, based upon the observations of Dr. Morrill, of Pepperell, Mass., who had isolated two varieties of diplococci, both of which inoculated upon healthy subjects produced lesions characteristic of the disease. One was a non-chromogenic organism which produced pityriasic manifestations, the

other, chromogenic, produced lesions covered with yellowish greasy scales. Both together caused greasy crumbling scales. These experiments, the reader thought, showed the really parasitic nature of the affection.

Dr. JACKSON had claimed for several years that seborrhœa was at the foundation of a large proportion of cases of alopecia.

Dr. ZEISLER believed seborrhœa the most frequent cause.

Dr. WHITE said in the vast majority of cases the conditions were not present which would warrant the term dermatitis. He thought the percentage of hereditary cases large, and that frequent washing of the head had something to do with loss of hair.

Dr. BULKLEY was convinced of the parasitic origin in a large number of cases. He advocated coarse dark bread and the avoidance of fine white flour. Resorcin was of great service.

Dr. WIGGLESWORTH spoke of the importance of diet. He did not believe in heredity, but favoured contagion as a cause, and warned against the careless use of brushes, &c.

Dr. ROBINSON did not think the condition a dermatitis, but rather an hypertrophy of epidermis causing pressure, and thus impeding hair growth. He had found what he called the staphylococcus epidermis albus, an organism very difficult to remove from the skin, and wondered if it had any relation to that found by Dr. Morrill. He had injected pure cultures into the scalp and produced patches of baldness.

Dr. BOWEN is not convinced that the dermatitis in these cases is primary and predominant.

Dr. SHERWELL thought the paper an important one, and that the report should receive careful consideration.

Dr. ELLIOT said Dr. Morrill's germ was a diplococcus and not a staphylococcus.

Election of Officers.

President, Dr. A. R. Robinson, of New York; Vice-President, Dr. F. J. Shepherd, of Montreal; Secretary and Treasurer, Dr. C. W. Allen, of New York; Member of Council, Dr. J. T. Bowen, of Boston.

An afternoon session was held on the nineteenth at the Montreal General Hospital, by invitation of Dr. Shepherd, where he presented a number of interesting cases, including:

1. A very aggravated instance of acne indurata, with keloidal formations disfiguring the whole face.

2. An extreme case of varicose veins of the leg, upon which Dr. Fox, of New York, took the opportunity of demonstrating his circular elastic bandages, which the patient stated gave him decided relief.

3. Lymphatic stasis of the arm in a man.
4. Xanthoma tuberosum in a woman.
5. Ichthyosis hystix.
6. A case of elongation of leg in a patient who has had for years a pustular and ulcerative skin eruption attended by scarring; exhibited by Dr. A. Hutchison.

These cases were examined and discussed, and Dr. Fox explained the utility of his bandage, which consisted in a series of rings constructed from elastic webbing, and varying in circumference according to the portion of the limb which they were intended to surround. They are to be fitted from below upward, each overlapping the other so as to make an even firm bandage.

Dr. KLOTZ, of New York, read a paper on

The Infected Scratch and Its Relations to Impetigo and Ecthyma.

The slight skin affections occurring in daily life deserve attention as well as the rare diseases. The condition which for the present is designated as the infected scratch has no place among the diseases recognized by the Association, although it is so commonly met with, especially in public practice.

Disseminated lesions of different size characterized by irregular pustules, thin blackish crusts or moist surfaces covered with pus. There is no symmetrical arrangement or grouping. There may be slight loss of substance under the crusts. In adults the lesions are usually on the lower extremities, in children about the face. Some source of irritation can usually be found. The habits are usually faulty and pediculosis is commonly present. No doubt suppuration is due to infection with pus producing cocci. Impetiginous eczema is a diagnosis often made to cover such cases. Bockhart's "accidental impetigo" seems identical with the author's "infected scratch." In most instances the author is inclined to consider ecthyma as an aggravated form of the infected scratch.

From 1877 to 1893 inclusive there were reported to the Association 2,612 cases of impetigo. It is considered highly improbable that these are to be looked upon as instances of Duhring's impetigo, which is considered rare. Probably a large number were instances of infected scratch. He would gladly see the term impetigo abolished, and suggests pyodermia circumscripta superficialis, of which we could distinguish two forms, the idiopathic and the traumatic.

Dr. White, of Boston, read a paper on "The Prevalence of Germ Dermatoses," and Dr. Bulkley, of New York, on "Sleep in Relation to Skin Diseases," the abstracts of which have not come to hand.

After the usual votes of thanks the meeting adjourned.

THE

Montreal Medical Journal.

A Monthly Record of the Progress of Medical and Surgical Science.

VOL. XXIV. NOVEMBER, 1895. No. 5.

THE MEETING OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.

We give in this number an interesting report of the meeting of the above mentioned Association held in this city in the month of September last. The meeting was in every way a most successful one, both as regards number of members attending and value of papers read. The members of the Association were entertained at luncheon on the afternoon of the second day, and afterwards driven about the city. The last session was held at the Montreal General Hospital, where Drs. Shepherd and Hutchison shewed a number of interesting skin cases, which were examined and discussed by the members. This Association, which is composed of the leading dermatologists of America, has done much to advance our knowledge of skin diseases during its existence, now nearly twenty years. Among its members are such men as Duhring, of Philadelphia; J. C. White and Wigglesworth, of Boston; Bronson, Bulkley, Elliot, Fox, Morrow, Piffard and Taylor, of New York; Hyde and Zeisler, of Chicago; Atkinson and Morison, of Baltimore; Hardaway, of St. Louis; Corlett, of Cleveland, and many others. The Society consists of about thirty-five members all in active dermatological practice.

The next meeting will be held at the White Sulphur Springs, Virginia.

LAVAL UNIVERSITY.

The official opening of the New Building of Laval University in this city, which took place on the 8th October, proved to be highly successful.

The Rev. J. B. Proulx, the Vice-Rector, occupied the chair and discharged his duties in a very creditable manner.

The first speaker of the evening was Dr. Rottot, the Dean of the Medical Faculty. His address was an able account of the recent advance in scientific medicine. He also dwelt on the past medical history of Laval University and the prospects for the future.

Addresses were also delivered by the Revd. L. Colin : Judge Jetté, the Dean of the Faculty of Law ; Rev. C. Lecocq, Dean of the Faculty of Theology ; Mr. Nantel, Mr. J. J. Curran, the Lieut.-Governor of the Province of Quebec, and by Mgr. Ed. C. Fabre, the Archbishop of Montreal.

The new building of Laval is a beautiful structure situated on St. Denis street, and will, when completely furnished, be a home of which any University may be proud. We congratulate the authorities of the University on the energy and spirit they have displayed in erecting such a fine structure, and heartily wish them success in their endeavours to place the Montreal branch of Laval in a position to adequately meet the educational wants of the rising generation of the French-Canadian population.

The American Year-Book of Medicine and Surgery is to be ready for delivery by the beginning of the year. It will be edited by George M. Gould, A.M., M.D., assisted by a staff of American physicians and teachers, and will be published by the well-known firm of W. B. Saunders, of Philadelphia. It aims to place before the physician in a convenient form an epitomization of current literature made by competent writers. Not only will the contributions to American journals be reviewed, but also the discoveries reported in the leading medical journals of Great Britain and Europe. These reviews will include only what is new, and the treatment presented will be synthetic and dogmatic. The illustrations will be carefully selected with a desire to fully illustrate the text, while adding to the attractiveness of the volume. We wish Mr. Saunders success in his new venture, which, coming from such a source, should command a large circulation.

Obituary.

THE LATE PROFESSOR HOPPE-SEYLER.

To the list of illustrious men who have recently joined the great majority must be added the name of Felix Hoppe-Seyler, Professor of Physiological Chemistry in the University of Strasburg, whose death on the 10th of August last, left a great blank in the scientific world, and sent a pang of regret through the hearts of scores of this great teacher's former pupils. The end was the more painful to them as it had been arranged to hold a jubilee in a few months, when the veteran investigator and beloved teacher would have completed his 70th year.

Hoppe-Seyler graduated after thorough studies under many distinguished teachers, including Johannes Müller, in 1850 as doctor of medicine, and in 1854 became prosector of anatomy at Griefswald.

In 1856 he became Virchow's assistant (chemist) in the Pathological Institute at Berlin. This was really a very important event for Hoppe-Seyler and the medical world, inasmuch as it probably determined the career of this young chemist and physician. It moreover does infinite credit to the foresight of the great pathologist, and stamps him as one of the prophets of medicine. A few years later the young chemist went to Tübingen as professor of chemistry, where he remained till he migrated in 1872, after the close of the Franco-Prussian war, to the recently founded University of Strasburg.

His new laboratory was a beautiful and admirably arranged building, and none probably appreciated its beauty and its facilities more than the distinguished worker himself, for when the present writer had the pleasure of spending a winter in this institute in 1883-84 the old laboratory was pointed out to him—a sort of dungeon in the basement of the Anatomical Institute. Nevertheless, from this miserable workshop teemed forth the results of research after research, and, in fact, in it were laid the very foundations of physiological and pathological chemistry, though much had been previously done in Tübingen. The researches there undertaken and carried to a successful issue by himself and his pupils were published, in collected form, under the title of *Medicinische Chemische Untersuchungen* in 1877. In 1881 his *Physiological Chemistry*, the most exhaustive text-book on this subject extant, appeared. The author is, however, best known,

perhaps, by his *Practical Handbook of Physiological Chemistry* which passed through many editions.

Hoppe-Seyler's laboratory was the resort of students from all lands, and many of these are famous in the department which their master may be said to have established, while still more have made use of the knowledge and investigating power acquired under his guidance to advance the cause of scientific medicine in ways too numerous to attempt to detail.

Probably no man ever came under the influence of this remarkable teacher who was not greatly impressed by him, alike as a scientist and as a man.

The writer spent in his beautiful new laboratory, within a few feet of the great Strasburg fortification wall, a winter which proved one of the most pleasant and profitable of his life, for which he has to thank the genial assistants in this and other laboratories, among them Dr. Thierfelder, now in charge of physiological chemistry in the Physiological Institute at Berlin, but most of all the veteran teacher and investigator who was ever the soul of the place.

When one comes to consider how difficult it is to adapt chemical methods to the needs of the medical student and the general practitioner, one wonders at Hoppe-Seyler's success in this direction as evidenced in his Handbook.

It was his custom to visit the laboratory, in which his pupils worked, at least twice a day. He gave personal attention to every student, and while there were in my time two assistants to whom we might refer, the professor did not relegate even the most elementary workers to the assistants. The veteran teacher approached each man with a bright face, and his inquiry often took the form of "*Nun?*" This we all understood to be the signal for a recital of the details we had been endeavouring to carry out.

Though he understood and read English, he rarely attempted to speak in that language, but the writer has never heard any German use his mother tongue in a way so easy for a foreigner to understand.

The professor was a man of method and even, when no longer young, of apparently boundless energy. His knowledge of the literature of his own subject was complete, and his criticisms were pointed and just. These qualities, with an enthusiasm, singleness of purpose and unrelaxing persistence, associated with good natural mental endowments, go far to explain the enormous amount of successful work accomplished throughout a long life, and which old age did not seem to diminish, for he was a teacher and investigator to the last. He was the originator and the editor for the now twenty years of its

existence of the *Zeitschrift für Physiologische Chemie*, the most valuable periodical of the kind published.

Hoppe-Seyler's work included almost every conceivable topic in physiological and pathological chemistry and was not confined to animal life alone ; and no better illustration of the assiduous cultivation year after year of a single field can be found than his work on the pigments of the blood.

The writer happened to be a worker in the new Physiological Institute when it was publicly opened with a remarkable address by the great pioneer himself in the presence of the *élite* of the entire university, and so aroused was he by the address that he translated it on his return to Canada and published it, with the consent of its author.

Professor Hoppe-Seyler's career has always been, like the man himself, an inspiration to those who have studied the one and fallen under the personal influence of the other. What a noble illustration of powers well used, of a genial, kindly and unusually courteous bearing combined with inflexibility of purpose and high ideals ! What fruit for the world of the past, the present, and the future, from his honest, steady, well directed work ! The man will live in the hearts of his pupils, one of whom the writer would, were he worthy, gratefully subscribe himself.

Wesley Mills.