

Technical and Bibliographic Notes / Notes techniques et bibliographiques

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

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

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

Continuous pagination.

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

CANADA

MEDICAL & SURGICAL JOURNAL

DECEMBER, 1882.

Original Communications.

REST AND TRACHEOTOMY.

By GEO. W. MAJOR, B.A., M.D.,

Late Clinical Assistant, Hospital for Diseases of the Throat and Chest,
London, Eng.; Out-Patient Physician & Surgeon to the Montreal
General Hospital; Fellow of the American Laryngological
Association; and Instructor in Laryngology,
McGill University, Montreal.

*(Condensed report of a paper read before the Canada Medical Association, at
Toronto, September, 1882.)*

The therapeutic value of rest in medical and surgical disease, now so thoroughly recognized, applies with no less force to the various diseases of the throat. There still seems to be a certain amount of doubt and indecision as to the best means of securing this end. In tonsillar inflammation, how keen is the suffering of the patient in attempting to swallow saliva or nourishment. This pain is largely the result of motion, and would at once suggest to a thoughtful practitioner the idea of rest. Perfect rest cannot be secured; modified rest can be, and yet how common it is to order a gargle. By gargling, I mean gargling in the common sense of the term, in which act the head must be thrown back, the liquid held between the anterior pillars, soft palate, and the base of the tongue, the air forced up to throw the liquid into motion, requiring a forcible expiratory effort, indicating the presence of motion and the absence of rest; when an inspiration is necessary, the head must be thrown forward, so as to prevent the passage of the liquid beyond the anterior pillars and velum, otherwise a drop of liquid would of necessity enter the larynx

and produce a violent paroxysm of coughing—a further violation of rest. The needlessness of this procedure is evident. The expiratory effort does not bring the liquid any more thoroughly in contact with the inflamed part, and necessitates a degree of movement detrimental in every way. A gargle is at best a mouth-wash ; it does not come in contact with the diseased surface as a rule, it certainly does not come in contact with the pharyngeal walls, it may, under exceptionally favourable circumstances, with the tonsils or perhaps posterior pillars. When a gargle is necessary, the head need only be thrown back for a moment, during which time respiration is suspended. The thoroughness of this application will be found quite equal to any more complicated movement. If any doubt should exist as regards the mechanical principle of the gargle, it can be simply demonstrated by the use of a coloured liquid, which will leave its stain on all parts with which it comes into contact. The examination must be made immediately after the ejection of the liquid, otherwise, in swallowing the residual portion may lead one astray, by colouring parts before unreached. It is a common habit for a patient to rinse the mouth after using a gargle ; this procedure defeats the only good a gargle can do, for it removes from the mouth any small portion of medicament left in the salivary secretions which, in the act of swallowing, would necessarily come in contact with the parts we seek to affect.

But it is more especially in relation to the necessity of physiological rest of the larynx proper that I desire to speak, and hope to show that all treatment, general and local, of acute and chronic diseases of the larynx, in which the principle of rest is violated, places practitioner and patient at a great disadvantage. We recognize two especial functions in relation to the larynx—the respiratory and phonatory, not to mention that of deglutition, in which latter the larynx is unavoidably concerned. In the respiratory act the intrinsic muscles are almost constantly engaged in active work. Each inspiration enlarges the rima, by separating more widely the vocal bands ; when this act is complete, there is a slight pause, then expiration begins, and with it more muscular action, though of a nature less forcible than that

required on inspiration. During mental or physical excitement the number of respirations per minute increases in order that the pulse-respiration ratio may be maintained. This increase means additional work thrown upon heart and larynx alike. In affections of the heart, organic and functional, we are most careful to avoid everything that will tend in any way to increase the amount of work the central organ of circulation is called upon to perform. In laryngeal disease many of us have yet to learn this lesson. Phonation, unlike respiration, is immediately under our personal control, and every effort in that direction, whatever its intensity or quality, involves to a greater or less extent the approach of the vocal bands. The amount of movement and tension necessary is in direct proportion to the intensity of the effort and the length of time through which it is sustained. The injury resulting from this movement will depend largely upon the diseased condition and the parts involved. In public speakers, where, as a rule, only the vocal bands are affected (thickened), the hoarseness of tone gradually disappears on using the voice, but not without leaving an after sense of fatigue. This, perhaps, argues in favour of a certain amount of exercise. Where, however, pain is evinced, absolute rest, of course, suggests itself.

It might be as well here to call attention to the fact that whispering is not rest, but, on the contrary, involves much more fatigue, distress, and effort, than speaking in an undertone. In the production of a whisper, the vocal bands are held in a position midway between adduction and abduction sufficiently close to produce a rushing sound when the current of expired air meets them, but not near enough to permit of vibration of the bands. Over-rest, on the contrary, might, on general principles, be regarded as detrimental. No joint can sustain absolute rest for a very prolonged period without detriment: the articular surfaces become changed, less elastic, and more vascular, giving rise to pain in motion. This latter statement might be held to apply to the articular surfaces of the laryngeal cartilages, where pain and a tired feeling result after use. There is a difference between laryngeal and other articular surfaces: that whereas, in the latter, mechanical appliances aim at and attain perfect

rest, in the former, rest from phonation is not absolute rest, as the function of respiration is maintained, entailing gentle, but constant motion, asleep or awake; so that the danger resulting from perfect rest in other joints does not, in its entirety, apply to the larynx, unless under the conditions developed by directing the current of air through an artificial channel, which will be noticed in speaking of tracheotomy, as the only means of securing absolute, perfect rest.

Speaking in general terms, the degree of rest necessary to be enforced in any given case must depend largely upon the morbid condition, the continued laryngoscopic examination of the patient, and the experience and judgment which the practitioner may bring to bear in conducting his experiment. In acute laryngitis, absolute rest of the voice becomes the most important factor. All efforts, mental or physical, which would tend to increase respiratory action must be desisted from. Every infringement of this rule must only increase the obstinacy of the attack. Rest may be supplemented by other means of an antiphlogistic nature, but I do not hesitate to say that, in a large majority of cases, rest in itself will be sufficient. Where much constitutional disturbance exists, the internal administration of remedies will, of course, suggest themselves. Soothing inhalations will be found valuable, as also the application of ice externally. Inhalations should not, however, be used when the submucous tissue is involved, otherwise increased swelling will result. In the use of inhalations some caution is necessary. An inhalation should not be used at a higher temperature than 140°F ., nor for a longer period than five minutes at each sitting, nor should more than 10 or 12 inspirations be taken in each minute. The violation of these rules will only lead to exhaustion, exhaustion to over-action, and over-action to defeat of the principles of rest. The internal administration of bromide of ammonium I find especially useful, and attribute its benefit to its local anæsthetic power and the rest thus secured.

In chronic laryngitis, we meet with somewhat different conditions. The action of the intrinsic muscles is interfered with, as in these cases, especially if of long duration, more or less

plastic exudation between the muscular fibrillæ has been thrown out, and must, of course, be got rid of before we can expect restoration of the functional activity of the vocal bands, which we find more or less thickened and congested. However valuable the local treatment by stimulants and astringents may be, and however near we may approach, through their aid, to a satisfactory cure, we shall find that here, also, rest is necessary, otherwise we may hover on the verge of convalescence, without ever attaining it. However well the larynx may appear to a cursory observer, on testing the production of the voice, we shall find the tension of the bands interfered with, owing to the loss of muscular power sustained. Moreover, we may have added an involvement of articular surfaces, which, in itself, will present an obstacle of no small proportions, however otherwise healthy the mucous and muscular condition may be.

Subacute laryngitis occupies an intermediate position, and no rule can be dogmatically laid down for observance of rest. Fighting off the effects of cold or hoarseness by increasing the muscular strain cannot, in my opinion, but be productive of harm.

A variety of opinion exists with regard to the extent to which rest should be carried out in these cases. They are extremely common, and if each case were treated on its own merits, I do not think such divergence need exist. As a general rule, some faulty method in voice production, over use of the voice, or singing unsuitable music, will be found to be the origin of the evil, and we should at once seek to find a remedy from such a cause. These cases usually occur in professional voice users, among those who cannot avail themselves of phonetic rest; we must therefore caution them to secure as much rest as possible, by making the amount of vocal work small, by using the voice for short intervals, and by ceasing from all vocal exercise, if possible, should fatigue or pain present themselves, until such a time as we can see that the tensor and adductor muscles during efforts of phonation act with promptness and vigor. If we see an oval chink, even during rendering of high notes, we may safely say that we must look to complete rest for the only remedy. Should we persevere in the use of the voice, we may look for

total disability, a condition that more frequently follows subacute than acute disease. It is through operative interference alone that we can secure to the larynx perfect and absolute rest. I shall trust to a short narration of a few of the cases that have presented themselves to my notice for the vindication of the principle. I shall not attempt here to overcome the prejudice of the laity and profession against opening the air passages, except in cases *in extremis*. I am satisfied, from my own experience, however limited that may be, that were this operation resorted to more early, this prejudice would largely cease to exist. In diphtheria, for instance, the operation is resorted to, generally, when the mechanical obstruction to breathing is so great that suffocation must otherwise result.

In diphtheria of the pharynx and neighbouring parts, I have been in the habit for the past two or three years of carrying out the suggestion originally offered by Dr. Morell Mackenzie, of coating the surface with an ætherial solution of a gum, applied by means of an atomizer. Dr. Mackenzie advanced the idea that these applications acted by excluding air and preventing absorption of moisture. I certainly agree with him in this opinion, but also consider that they act through the rest they secure. The irritable condition of the fauces existing in this disease is thoroughly well recognized, the contracting power of disseminated patches most likely being the cause, as I have observed that where the surface was pretty equally covered, the irritability seemed less. This varnish (for such it is) seems to equalize the tension and render this cause of discomfort much less. The application, though at first smarting, gives relief to reflected pain. This relief I greatly attribute to the rest obtained. If diphtheritic exudation in the larynx were more closely followed by the intelligent use of the laryngoscope, timely operative interference would probably yield much better results, as we should, at least, render ourselves sooner independent of the passage rendered unequal to its work, not only by the mechanical interference of the membrane itself, but also by the influence which the presence of the foreign body has in producing spasmodic action of the adductors. We should also be in a much better position to contend with the

constitutional poison by at least affording a full and sufficient supply of pure air, leaving altogether out of the question the important factor of rest.

Last October, 1881, a young person was referred to me for admission into the hospital for an acute disease unrecognized. Her voice seemed to me somewhat muffled—so much so, in fact, that I at once suggested and carried into effect a laryngoscopic examination. The result was that I discovered, at the anterior commissure of the vocal bands, and extending somewhat more to the right than the left, a patch of diphtheritic exudation, irregular in shape, and of the area of a split currant. On rhinoscopy, some small patches were found in the posterior nares. On the following day the membrane in the larynx had extended over the anterior half of the right cord, violent spasmodic breathing being the result. Forty-eight hours afterwards I was forced to resort to tracheotomy. Owing to the irritable condition of the stomach, I ceased to administer drugs, relying solely upon nourishment and sprays to the posterior nares and larynx. I watched carefully the condition of the larynx; the exudation ceased to extend, the congestion was relieved, and the patient's condition improved, so much so, that in ten days more I was enabled to withdraw the tube. As some interference with abduction still existed, owing, I presume, to spasm of the adductors, I enjoined perfect rest of the voice and the avoidance of active pursuits. This case in itself contributes in some slight degree to uphold what we may look for in rest, other things being equal; as not only did the exudation in the larynx not increase, but the surrounding congestion was relieved, the glottic spasm overcome, sleep of a gratifying character secured (a matter of no small importance in laryngeal diphtheria), and a bountiful supply of vitalizing oxygen afforded, and a good recovery the result.

In the spring of 1881, a child of 4 years was referred to me, with extensive warty growths of both vocal bands. After attempting a variety of treatment, tracheotomy became necessary, and was performed, with the valuable assistance of my friend Dr. Shepherd. Local and constitutional improvement followed. Seven months later I plugged the tube, and

found congestion increase, and subsequently the warty growths showing renewed activity. After three weeks I again removed the plug, the papillomata once more diminishing, until in Aug., 1882, the child, previously completely aphonic, had almost regained her natural voice.

In primary laryngeal cancer, one's experience is limited.

W. H., aged 68, referred by my friend Dr. Blackader for a laryngeal tumour rapidly developing, I diagnosed malignant disease of the right ventricular band. In a few days the breathing became so much embarrassed that I decided upon the immediate necessity of operative interference. Accordingly, with the assistance of Drs. Blackader, Browne and Shepherd, I tracheotomized. On subglottic examination, I found no extension below the floor. The man's condition materially improved, the acute shooting pains were relieved, and my patient expressed himself as highly gratified with the result. No extension of the tumour took place into the larynx; the thyroid isthmus and bodies showed induration three or four months afterwards, as also did the tissues in the neighbourhood of the wound. Post-mortem, extensive ulceration of the trachea was found. Death was due directly to cachexia, and was almost painless. Previous to the operation the man showed marked delirium. The operation relieved this. The arrest of the growth and the prolongation of life, I do not hesitate to say, were due directly to the rest secured by the operation.

The second case, now living, was Mrs. D., aged 60, referred by Dr. Laphorn Smith. In this case an early diagnosis was made. The tumour occupied the posterior half of the left ventricular band and arytenoid, and was under observation for five weeks previous to operating, during which time Dr. Smith continued the use of astringent and sedative applications, and administered, on my advice, iodide of potassium liberally. No improvement resulted, and tracheotomy became a necessity. On the 4th of May, 1882, I assisted Dr. Smith to operate. I have frequently seen the patient since (and although no ultimate good can result, her friends at least will be saved the pain of seeing their relative succumb amid the writhings of strangulation), and

find there has been a marked diminution in the tumour, a comparative freedom from cough and pain, an improvement in deglutition, to say nothing of the improvement in the general health.

That improvement should follow rest in cancerous disease of the larynx is not to be wondered at, when we remember that in malignant disease of the rectum, the operation of colotomy is frequently followed by marked improvement.

While on the subject of laryngeal cancer, I will briefly refer to a point which further experience may yet develop into one of diagnostic value. Under the anterior border of the middle-third of the sterno-mastoid muscle of the same side on which malignant disease exists will be found a mass of indurated glands of from 2 to $2\frac{1}{2}$ inches in length, and of the thickness of the middle finger. This condition I have not observed in tubercular, syphilitic, or chondrial disease, nor in cases of œsophageal disease involving the lower pharynx, and I desire here to record it.

In tubercular disease, tracheotomy has been resorted to when swelling threatened death by asphyxia. A middle-aged female following my clinic for considerably more than three years, with tubercular disease, was admitted into the wards of the hospital with an acute pleurisy, the result of exposure. After a few weeks she was referred to me for laryngoscopic examination. I found a tubercular condition, with great swelling, and reported the necessity of an immediate tracheotomy. On the same evening, Dr. Bell, the medical superintendent, was hastily summoned and found it necessary, in the emergency, to open the air passage with an ordinary penknife. Resorting to artificial respiration, he succeeded in reviving the patient. Some eight or ten months have elapsed, the tube is still worn, the laryngeal condition is improved, and the disease in the lung apparently arrested.

Though tracheotomy, or rather the rest it secures, does not offer much hope of ultimate recovery in these cases, it sometimes stays disease by removing at least some of the exciting causes, it relieves the diseased laryngeal structures from contact with the irritating air, lessens cough, and affords perfect rest, ulcerations heal, swellings diminish, and comfort is secured. In injuries to the larynx from scalding water, steam, or destructive

agents, rest will accomplish in a few days what would otherwise take weeks. Comparative physiological rest may also be obtained by the local use of sedative and astringent applications. Nitrate of silver affords a striking example of this, forming an albuminate or chloride, thus protecting the ulcerated surface from irritating contact, thereby lessening the recurrent spasm of the vocal bands and irregular contractions of the intrinsic muscles, as the mucous membrane and the intrinsic laryngeal muscles are supplied alike by the pneumogastric nerve. The physiological rest secured by the silver application makes itself often felt in the complete recovery from morbid states. The influence of rest may be further exemplified by the fact that where a tracheotomy has had to be performed for breathing purposes, ulcerations that had previously obstinately refused to yield, rapidly take up healthy action under the same medicinal agents to which they had previously refused to surrender. In spasms of the glottis of an obscure nature, tracheotomy frequently affords relief by the rest it secures when the tube is worn for a sufficiently long time. When it is necessary to continue the use of a tube over several months, or longer, I would suggest the use of gold for the outer tube, preferably to any other metal. Gold will be found much less irritating to the wound and much cleaner, opposing, as it does, the chemical action of mucus, bronchial and traumatic secretions. A lighter tube, also, will be equal in strength to a much more heavy one of silver, and the cost will not be more than double. I am not aware of the use of gold having been previously recommended, and take this opportunity to do so, with confidence as to the result. In hysterical aphonia (so-called), rest, if enforced, can work wonders. I can call to mind, at least three cases, where rest from all attempts at phonation gave good and rapid results after medicinal dosing and all manner of treatment, threats and entreaties not excepted, had proved an ignominious failure. I advanced the theory some two years ago that this condition was the result (among other causes) of the attempt to phonate on inspiration instead of expiration; that this was the result of a faulty habit, and could only be rectified by observing absolute rest of voice, unless when undergoing a daily course of vocal

gymnastics, the laryngeal mirror being held in position; and that thus the action of the bands might be observed, and a suitable course of instruction adopted.

CLINICAL NOTE ON HÆMATEMESIS IN CHRONIC SPLENIC TUMOUR.

By WM. OSLER, M.D., M.R.C.P., LOND.

Professor of the Institutes of Medicine in McGill University, and Physician to the Montreal General Hospital.

Hæmorrhages are very common in all forms of chronic enlargement of the spleen, more particularly in that accompanying leucocythemia. A depraved blood condition would appear to be the main factor, as we meet with them in profound anæmias, not splenic in origin. Epistaxis is the most frequent, and next hæmorrhage from the bowels; hæmatemesis, hæmoptysis and hæmaturia are occasionally met with. Of 150 cases of leucocythemia collected by Gowers, hæmorrhages occurred in 80, and 8 of these from the stomach.

The point to which I wish to call attention, and which is illustrated by the cases, is the occurrence in some instance of severe, perhaps fatal, hæmatemesis at an early stage of the splenic trouble, even before the constitutional symptoms are marked. Indeed it may be the first symptom for which the patient seeks assistance, or, proving fatal, the only one, and the nature of the affection is entirely overlooked. The importance of the fact is chiefly from the diagnostic standpoint, and in an attack of vomiting of blood, the attention should always be directed to the spleen, as well as to the liver, as a possible cause. The cases are as follows:—

CASE I.—J. H., aged 36, admitted to Hospital on Sept. 2nd, 1879, with anæmia. Served seven years in the army in India, and had intermittent fever. Has been a healthy and temperate man. Since his discharge from the army, has lived in Canada, and has enjoyed good health. In January, 1879, he had an attack of vomiting blood, which was preceded by a slight indisposition, a feeling of weight about the abdomen, and nausea. The bleeding occurred three times in a week, and on each occa-

sion he lost a large amount, and was much reduced. His strength returned slowly, and he resumed work. In July, the bleeding recurred—a single, large hæmorrhage. In January, '79, he noticed that the abdomen was a little prominent, particularly in the upper part. Later on it was not so evident, but he began to feel weak, lost his colour, and was not able to work. In July he had a severe attack of diarrhœa, and, shortly after, another hæmorrhage. For the two months before admission, the belly increased considerably. When he came under observation, there was marked anæmia, abdominal distension, and œdema of the ankles. The spleen was considerably enlarged; dulness extended from lower border of 8th rib, a distance of $7\frac{1}{2}$ inches in the axillary line. It could be felt; it was felt as a distinct tumour emerging beneath the left ribs, and extended to the navel, and when he stood up, the lower edge reached two inches below this point. It was not painful. There was some fluid in the peritoneum. The blood was thin and watery, and, microscopically, presented the characters of anæmia. The red corpuscles were greatly reduced, under two millions to the cubic millimetre, and the hæmoglobin was correspondingly diminished. There was no leukæmia. The heart's action was always a little excited; pulse about 100; hæmic murmurs present. Sweats were troublesome. He remained in hospital a month, taking iron with benefit; the œdema of the ankles disappeared, and the belly diminished in size. He had no hæmorrhage. He was taken to Glengarry by his friends, and I heard from his sister that he died some weeks after from the effects of a severe hæmatemesis.

CASE II.—On the 13th of August, of this year, I was consulted by Mrs. —, from Kingston, who brought her little girl, aged 11, for examination. She gave the following history:—

Nothing special in family; one child had died of phthisis. This one had been healthy; but two years ago, after a slight indisposition, she had a severe attack of hæmatemesis, lasting over twelve hours, during which time she vomited a basinful of blood. She had some pain in the abdomen, which also appeared swollen. Four years ago she was not well, and the mother thinks that then there was vomiting of blood-tinged matter, but

this is doubtful. She recovered from the bleeding in 1880, and seemed to thrive like the other children, though paler. In July last, just a month ago, a brother died, and the excitement at the time brought on another attack, which lasted 36 hours, and she lost nearly three quarts of blood. She picked up rapidly, and from her general appearance I could scarcely credit that she had lost so much blood only a few weeks previous. She was a well-nourished, stout girl, but the face was pale, and a puffy look about the eyes. She complained of an uneasy feeling and fullness in the stomach. The feet swell in the evenings, and she is short of breath when walking fast or going up stairs. Lately her appetite has failed.

On examination, nothing abnormal was detected in heart or lungs; sounds clear, no murmur. Abdomen a little distended; panniculus adiposus thick; palpation revealed a splenic tumour in the left hypochondrium, extending three inches below the costal border, and to within an inch of the navel; the edge was clearly felt. It was not painful. The liver was not enlarged; no distension of abdominal veins; no signs of ascites. Blood thin; corpuscles normal as regards size and general appearance; no special increase of the colourless elements. Red per cubic mill., $2\frac{1}{4}$ millions; ratio of white to red, 1 to 316.

Dr. Howard has kindly permitted me to refer to the following cases, which illustrate the same point. In both I performed the autopsy:—

CASE I.—A plump, well-nourished lad, aged 13, had, on April 12, an attack of vomiting of blood, and shortly after had a large bloody stool. Four years before, he had been unwell, and passed blood from the bowels and was pale. On the day before the attack he had played "lacrosse," and seemed in fair health. The spleen was found to be enlarged, extending a hand's-breadth below the costal border, and the blood was leukæmic. The vomiting recurred, and he lost altogether about four pints. On the fourth day, he died from the effects of the repeated hæmorrhages. At the autopsy, spleen found much enlarged; weighed 480 grms. No erosion or ulceration of the stomach; mucous membrane pale.

CASE II.—A young lady, aged —, daughter of an American physician, studying French in the city, was suddenly attacked with violent hæmatemesis, which proved fatal in 24 hours. She had been in apparently good health, was well-nourished, and neither she nor her friends suspected any disease. At the autopsy, the spleen was found enlarged and firm, and the blood in the portal vein was markedly leukæmic. A peculiar malformation was met with in the portal vein, which presented a double trunk.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.

Demonstrator of Anatomy and Lecturer on Operative and Minor Surgery
McGill University; Surgeon to the Out-Door Department of
the Montreal General Hospital; Consulting Surgeon
to the Montreal Dispensary.

Bone-Setting (so-called).—What is generally known by the above name, but which is more properly called “Forcible Extension or Movement in Stiff Joints,” was the subject of two papers at the last meeting of the British Medical Association. The first paper was by Mr. Howard Marsh, F.R.C.S., and the second by Mr. William Adams, F.R.C.S.

Mr. Marsh (*Brit. Med. Journal*, October 7th, 1882) remarks that the value of manipulation in the treatment of stiff joints has of late years been attracting increased attention because it has been the fashion for many of the public to place themselves in the hands of bone-setters, and that no doubt some people are much benefitted whilst others are injured. Mr. Marsh says bone-setters are a very miscellaneous group, who resemble each other mainly in the negative point, that they are completely ignorant of Anatomy, Pathology, or Surgery. Some are blacksmiths, others are shepherds. They stand in the same relation to Surgery as herbalists do to Medicine, and have existed in the remote districts of England from time immemorial. Again, we have bone-setters residing in towns who equip themselves with the names of the principal bones and muscles, hang up a skeleton in the consulting room to show patients exactly what is wrong, &c. This class employs anaesthetics freely, making

use of daily passive movements, rubbing and shampooing, and in spinal cases they often put on a Sayre's plaster jacket. In every case the bone-setter asserts that a bone is out and that he can put it in. A patient who consults a bone-setter is merely playing a game of hazard. His fate depends on what is the matter with him. If he has a stiff ankle after a sprain, he will very likely be cured; if he has a strumous joint, he will be more or less injured, while if he has a bunion or node on his tibia, he will find himself neither better nor worse. Mr. Marsh then goes on to relate a number of cases which were injured by going to bone-setters, especially patients suffering from tumours of bone. "But," he asks, "how is it that bone-setters sometimes succeed, where surgeons have failed"? and answers, "There is a considerable number of minor ailments of and around joints, that interfere with free movement or produce pain, such as adhesions, slipped tendons, hysterical affections, rigidity of muscles, &c. These conditions . . . have one point in common, that they may be cured by free movement." Bone-setting consists in the process of carrying the affected joint through its full natural range of movement in all directions, and especially in that direction where there is most resistance. If the knee is flexed it has to go straight, &c. In the majority of cases really little force is used, for an anæsthetic is often employed. Then, again, bone-setters acquire by practice much facility in handling and moving joints, they know how to seize a limb at an advantage, and where no anæsthetic is given, they take care to divert the patient's attention, so as to take the muscles off their guard. In most cases, very moderate force is needed to break down adhesions, and the less the force required to remove the impediment to motion the more sure the case. This fact might be clearly set before medical men, so that in future they will have less fear of doing injury by manipulation.

Manipulation is chiefly useful when healthy joints have their movements restricted by external adhesions or by rigidity of muscles, slipped tendons, &c. Joints after sprains, dislocations or fractures should not be too long fixed by splints and bandages. When joints are seriously diseased, manipulation will generally

do harm, and in cases of firm fibrous ankylosis, the restoration of movement is quite unlikely. The position of the limb may however be improved.

Joints that are fit for manipulation are those which, after injury, are cool and free from much synovial swelling, &c. Mere pain, if there is no heat in the joint, by no means forbids manipulation, on the contrary, it is a strong reason for using it. In certain cases where the diagnosis is obscure, but where there is no evidence of structural disease though the joint is stiff and disabled, manipulation under an anæsthetic often effects a cure. Some of these cases are hysterical, some are deep-seated adhesions, some slipped tendons, and some simple muscular rigidity. Manipulation must be supplemented by passive motion. Mr. Marsh ends his interesting paper by referring to the importance of attending carefully to the minor affections about the joints. By being remiss in these cases we open the door to bone-setting and we are apt to commit oversights that we cannot fail to regret.

Mr. William Adams in his paper (*British Medical Journal*, October 7th, 1882), strongly advocates the use of "Forcible Movement" in Stiff Joints. He arranges stiff joints as follows :

- (1) Cases of traumatic origin in healthy constitutions, generally occurring in the adult.
- (2) Cases after rheumatic inflammation of the joint.
- (3) Cases after strumous disease of the joint.
- (4) Cases of acute suppurative inflammation of pyæmic origin ; and suppurative inflammation in the neighbourhood of, and extending to, the joint.
- (5) Cases consequent on muscular contractions.

The first class of cases, as a rule, are favourable for treatment by forcible extension, and include stiff joints after dislocations, and fractures into joints or in their neighborhood, also stiffness following bruises and inflammation of joints.

Cases of the second class are also, as a rule, favourable ones for this treatment, whether the rheumatic affection be acute, chronic or gonorrhœal.

Classes 3, 4 and 5, Mr. Adams considers, are essentially

unfit for this method of treatment. In the last class, where stiffness is due to muscular contraction, forcible extension is injurious. They should be treated by tenotomy and gradual mechanical extension.

Mr. Adams deprecates violent extension, and says he has seen many accidents, such as fracture of bones, rupture of arteries, &c., follow its use. His method of procedure is as follows. In severe cases at the first operation, he uses only sufficient force to attain the least possible movement, then at successive operations, repeated at intervals of two or three weeks, he tears through the other adhesions and gradually increases the range of movement till the full extent is obtained; after each operation he applies hot water dressing, generally using spongiopiline and in the leg always makes use of weight extension. Absolute rest is essential, and in some cases he uses the local vapour bath two or three times a day. In simpler cases, a single operation will often suffice, but it is frequently necessary to repeat it three or four times.

Sir James Paget, in a Clinical lecture delivered in 1867, was the first to treat of the cases that bone-setters cure. This he did in his usual masterly manner; the lecture is published among his "Clinical Lectures and Essays." Among the affections of joints cured by bone-setters he enumerates, slipped tendons, locking of joints, especially the knee, injured joints held stiff by involuntary muscular action, stiff joints following sprains, and hysterical joints. He says, in the treatment of these affections we can learn to imitate much that is good in practice of the bone-setters. Dr. Wharton Hood in 1871 published a valuable little book on bone-setting. That bone-setters fail frequently to do any good and very often do great harm, is no doubt true, but with charlatans one success covers a multitude of failures. The victims of the bone-setter's skill rarely say much about their injuries. In many cases, indeed, the operator before commencing treatment demands written guarantees from the patient. Thus we only hear of the successful cases, the disasters being carefully concealed. There is an Italian woman in New York who has an immense bone-setting practice, and I know of several

cases that have gone to her, even from this city. Most of them being cases of hip disease were of course not benefitted, but all were guaranteed a cure, and some hysterical spines she certainly benefited. These cases, however, would be quite as successfully treated by prayer, mesmerism, or other extraordinary method. The regular practitioner is often to blame for manufacturing cases for charlatans to cure, as when after reduction of a dislocation the limb is kept too long at rest or manipulation is not practised after a Colles' fracture or a sprained ankle is kept up in plaster or starch for sometimes a month. No case of stiff joint due to ordinary fracture in neighborhood of joints or to the after effects of dislocation should be left to time to produce free movement. The surgeon should himself see the proper manipulations carried out and that the joint recovers its free range of movement. Bone-setters, in suitable cases, are less afraid of hurting the patient than is the ordinary practitioner, and although in many cases they do a great deal of harm, yet in many others their cures are very rapid, and to the public, marvellous. So the old adage is again proved true, that fools rush in where angels fear to tread.

Reduction of Dislocation of the Shoulder.—Every year new methods for reducing dislocation of the shoulder are brought out. M. Kocher, at the last International Congress (London *Lancet*, Nov. 4, 1882), read a valuable paper on this subject. In sub-coracoid dislocations, he asserts that the aim of the surgeon should be to open out the rent in the capsule and relax the parts of the capsule which are untorn but put on the stretch by the altered position of the head of the humerus. The rent in the capsule is on the inner side the most tense part, where it is thickened by the coraco-humeral band. The lower part of the capsule is also tense. Kocher asserts that by rotating the arm outwards, the top of the capsule is itself rotated out and the rent rendered patent: if now the arm be advanced in the vertical median plane, the upper part of the capsule is relaxed and, the head of the bone, being prevented passing forwards by the lower fibres of the capsule, enters the glenoid fossa. The following is his method of procedure. The patient should be seated,

with the surgeon on his left hand. The elbow joint is first to be flexed at a right angle, and the elbow firmly pressed against the side of the chest; then, while holding the elbow in contact with the body, the arm is to be slowly, gently and steadily rotated out until firm resistance is encountered; then maintaining this rotation the arm is to be raised forwards and a little in, and lastly to be rotated in and the hand brought to the opposite shoulder. It is stated that there is no need for anæsthetics when this manipulation is employed. M. Ceppi says this method is most valuable in old dislocations, they can be reduced without force and without anæsthetics. M. Kocher has succeeded in twelve cases of dislocations, varying from three weeks to four months old. In one case where the bone had been displaced for eight weeks, he fractured the shaft of the humerus in attempting reduction, and six weeks later, when the bone was united, failed again. This patient was seventy years of age.

This is certainly a very simple method of reducing dislocations of the shoulder, and is well worthy of a trial by surgeons. The fact that anæsthetics may be dispensed with is much in its favour, as in no operation have they, especially chloroform, been so fatal (why it is not known), as when used to cause muscular relaxation for the reduction of dislocations of the shoulder. The method much resembles that employed now almost universally for dislocated hips and is based on the same principles. Lately, I have used Sir Astley Cooper's method of operating with knee in axilla, with success, when I did not wish to give an anæsthetic.

Mr. James E. Kelly, F.R.C.S. Ireland, has lately advocated a method of reducing dislocations of the humerus (*Dublin Jour. Med. Science*, Sept. 1882), which in his hands has proved most successful. It is as follows: First the patient should be placed on a firmly fixed hard couch, which ought to be about three inches lower than the great trochanter of the operator. The patient should be placed as close as possible to the edge of the couch, on his back with his head low. The operator then places the injured arm at right angles to the body and standing against it, with his side to the patient and his hip placed firmly, but not

roughly, into the axilla, he folds the arm and hand of his patient closely round his pelvis and fixes the hand firmly by pressing it against the crest of his ilium; then the operator (with the patient's arm round his pelvis and his hip pressed into the axilla) turns himself rapidly so that his back is against the side of the couch. Mr. Kelly says one of the greatest advantages of this operation (which is more intelligible when the illustrations are seen) is the ease with which a surgeon can reduce almost any dislocation without assistance or anæsthetics. The scapula is fixed by being between the couch and the patient's body. This method appears very simple and easy of performance. The difficulty of having the proper couch always at hand would sometimes interfere with its employment.

Mr. Kelly has also employed a similar method for reducing dislocation of the hip, a full description of which may be found in the *Dublin Journal of Medical Science* for October, 1882. In the *Canadian Journal of Medical Science* for December, a writer describes a case of dislocation of the shoulder, in which Kocher's method signally failed, but Kelly's plan was entirely successful.

Radical Cure of Hernia.—The question of the most suitable operation for the radical cure of Hernia is still unsettled. Most of the operations are more successful in the hands of the originators than of any other, and no method has fulfilled the promises which accompanied its announcement to the profession. One method which according to report was always successful, is that practiced secretly by the late Dr. Heaton of Boston. Before his death he gave his method to the world in a little book published in 1877, and edited by Dr. Davenport. Dr. Heaton had for years treated herniæ by injecting solution of oak bark into the hernial ring to arouse sufficient inflammatory exudation to close the rings and then applying a peculiar bandage. Ten days rest in bed was all that was required. He also, in irreducible herniæ, made them reducible by daily manipulating the tumour and thus breaking down the adhesions. According to his book he often made these cases reducible in two or three days and then injected his fluid. Other cases of omental herniæ again he cut down upon and removed a portion, broke down the

adhesions between the sac and omentum, and returned the mass into abdomen. Mr. Heaton never had a fatal case during the whole period of his practice which was over 30 years. Surgeons, however, who have adopted his method have had but fair success with it. In the *New York Medical Record* for Nov. 11th, is an article by Dr. Wm. T. Bull of New York on Heaton's operation. He has performed the operation 49 times on 40 patients without any serious disturbance, but only in twenty-one can he report the ultimate result, the remaining nineteen have not been seen since leaving the hospital; of the twenty-one cases traced, five have been cured, seven improved, four temporarily improved, and five have not been improved at all. With one exception, all the operations were for inguinal hernia. Dr. Geo. W. Gay of Boston has operated twenty-three times, with the result of four cured, eight relieved, and three unrelieved.

At the end of his paper, Dr. Bull quotes and endorses Dr. Gay's general conclusions as to this operation, "I know nothing of the merits of the operation in other kinds of hernia, but in the one under consideration (inguinal), I can but conclude that it is safe. It is not very painful, it is not very difficult to perform, it does little harm even if it does no good. It will cure a certain number of cases and relieve others." Dr. Bull from his experience feels justified in recommending the operation, and he is sure that in another series of twenty cases he could greatly improve his record—and he hopes that his report of the operation will incite the profession at large to study its advantages.

Dr. Bull, who is a very able and skillful surgeon, deserves great credit for the way he has recorded his cases, although his success has not been so great as others, as, for instance, Dr. Joseph H. Warren, who *now* asserts he never has a failure, in his first series of cases he had *some* failures which he considered due to "imperfect instrument and crude injecting fluid," or Dr. H. S. Greene, of Kansas City, Mo., who had 91 cures out of 97 operations. It is certain that Dr. Bull's statistics are perfectly to be relied upon. Enthusiasts in any operation or mode of cure are very apt to look through rose-colored glasses and see cures where an impartial observer, such

as Dr. Bull, would only see improvement. Perhaps one reason Dr. Bull had not a greater proportion of cures is that he was satisfied with both Heaton's instrument and fluid, and did not invent a new instrument or a more effective injecting fluid!! This method of treating hernia by injecting the sac is an old one having been first introduced by Velpeau. Another of the recent operations for the radical cure of hernia, is that of Mr. William Dunnett Spanton. Mr. Spanton first described his operation at the meeting of the British Medical Association of 1879; since then he has contributed various papers to the Medical Journals narrating cases and describing his operation. The operation is performed with an instrument something like a cork screw, but with a flat point, so as to pass through the fibrous structures, without doing much violence to them; it is broader near the point than at the handle, so that as it is screwed onwards into the boundaries of the canal it approximates them to each other. The same preparation of the patient is made as for Wood's operation, by shaving the skin, incising it, and separating it from the subcutaneous tissue to such an extent as may be necessary to permit the invagination of the latter. The rupture having been reduced, the left forefinger is passed into the scrotal wound, pushing before it sac and scrotal fascia high up into the inguinal canal, so that the finger can easily make out the condition of the abdominal rings and the surrounding structures. The invaginated tissues being so held by the finger, the spermatic cord being protected by the finger, the point of the screw is, with the right hand thrust through the skin of the groin, so as to pass through the conjoined tendon at the internal ring in such a way, that the point comes against the tip of the left finger. The screw is next made to transfix the sac and fascia held in the inguinal canal, so as to pass across to the external pillar subcutaneously, a turn is then given to the screw so as to push it through the internal pillar of the external ring and again across to Poupart's ligament, the point emerging through the scrotal fascia at the wound, thus the sides of the hernial canal are approximated throughout, and the plug of invaginated tissue is firmly held in position while consolidation

is taking place. The handle of the screw then lies flat on the abdomen, the point is protected by a ball of india-rubber, and the scrotal wound closed by a suture of catgut, there is no hemorrhage. The screw is removed in the the 9th day, dressings relinquished in about two weeks, and at the end of a month the patient is allowed to get up, the parts being firmly consolidated. In sixty cases in which Mr. Spanton has operated (*Annals of Anatomy and Surgery, Oct. 1882*) all are now living, and in a large proportion of them a permanent and satisfactory cure has been effected, while in others the patients are so much improved that some who could not wear an effectual truss are now able to do so quite comfortably. In a small proportion the result has been almost nugatory. If a continuous ligature is preferred, the screw with a large eye at the point is passed in the manner described above, then threaded with a ligature when the point appears through the scrotal opening, and the screw gradually withdrawn upwards, the ligature following its track and occupying its place. In order to keep the ligature tight each end is fastened to a glass rod which lies in the groin until the parts are consolidated (in ten to fourteen days usually) the ends are cut off and the ligature remains. When this method of ligature is used operating under carbolic spray is desirable; but with the screw Mr. Spanton does not use the spray. The most satisfactory cases are those of congenital herniæ in the young, and the operation, says Mr. Spanton, is especially adapted for those cases in which the hernial aperture is large and the sac bulky, or when the congenital rupture is of old standing. This operation, which is a modification of Wood's and Wutzer's, is, according to the author, much less dangerous. All the cases operated on were of the inguinal kind. Mr. Spanton thinks that the wide-spread prejudice which prevails both amongst the profession and the public against operative interference in all cases of hernia, except when strangulated, is being rapidly overcome under the new era of antiseptic surgery. Many surgeons now cut down on the hernial tumor, reduce it and pass catgut ligatures through the pillars of the ring, so as to bring them together. By this method, Dr. H. O. Marcy

of Boston, Mr. Mitchell Banks of Liverpool, and others have had considerable success. Mr. Banks, at the last meeting of the British Medical Association, reported 30 cases in which he had cut off the sac and stitched the pillars of the ring together. There was no fatal case and only two failures, fifteen cases were completely cured, and did not require a truss. Dr. P. Kraske of Halle reports, in the *Centralblatt für Chirurgie*, No. 26, 1882, two cases of congenital scrotal hernia, in which Prof. Volkmann operated for radical cure. He remarks that the operation of exposing the pillars of the external abdominal ring, scraping their edges and bringing them together with catgut ligatures is only applicable to cases where the hernia is reducible, or in cases of irreducible hernia in which the obstruction is situated in the neck of the sac. The hernial sac itself must be destroyed to make a complete cure. If the sac can be isolated it may be ligatured, but as the sac in congenital hernia also forms the tunica vaginalis, its complete removal is out of the question. Volkmann's practice in these cases is as follows: 1, If the neck of the sac can be isolated, a ligature may be placed around it, the pillars of the ring brought together by sutures, and the interior of the sac washed out and drained. Simple transverse section of the sac or partial excision should be practised. 2, If the sac cannot be isolated, it should be treated with Wahl's suture or plugged with a stump of omentum, and then the sac should be washed out and drained. In old patients one should consider the advisability of castration. 3, Where there is incomplete descent of the testicle, if the sac can be isolated, it should be cut off. If it cannot be isolated, then castration should be performed.—(*Abstract from London Med. Record*, Aug. 1882.)

Removal of Portion of Intestines.—Dr. Wm. Fuller (late of Montreal, and now of Grand Falls, Michigan), reports in the *New York Medical Record* of Oct. 14th, 1882, several cases of the above. The first case was of strangulated femoral hernia in a woman, where on cutting down, the knuckle of intestine was found to be gangrenous. The intestine was divided a little beyond each extremity of the slough, and a double linen ligature

was placed around the mesentery. The mesentery was divided beyond the ligature, and with it five and a half inches of the bowel removed. The two cut ends of the intestine were brought together by a continuous ligature of carbolized shoemaker's thread. The ends of the thread were cut off and the bowel returned to the abdomen. The sac was cut off and a drainage tube placed in the wound. The dressing consisted of flannel cloth wrung out of hot water and applied over wound and lower part of abdomen; this was frequently changed. Immediately after operation vomiting ceased and the general condition improved. On the fourth day she had a natural stool. Thenceforth her recovery was uninterrupted, and in six weeks she was about doing house-work.

Another case is also reported where four inches of intestine were removed from a child for invagination. The invaginated portion was felt through the rectum, it was drawn out and cut off and then returned. The child recovered.

A third case is related where omentum was cut off and the bowel returned in an operation for strangulated femoral hernia. Next day flatus was passed through the wound and a drainage tube was inserted. Patient had a natural stool on eighth day, and afterwards her recovery was uninterrupted.

M. Roser (*Centralblatt für Chirurgie*) reports a case of resection of the intestine for acute femoral hernia in a female where death took place in 48 hours with all the symptoms of ileus. The autopsy disclosed the presence of a valve-like narrowing at the sutured spot; the gut below the suture was quite empty. On further examination it was seen that a swelling of a fold of the mucous membrane of the jejunum in combination with the sutured inversion of the edges of the wound in the gut, had produced the obstruction in question. This was attributed to a double row of ligatures which he had employed, eight internal and six external. These Roser thinks should not be employed in suture of the jejunum, but to obtain complete inversion of the serous membrane, he would advise that the lower mucous fold of the jejunum (which in transverse section usually becomes everted) be dissected off circularly in front of the stitch.—(*Edin. Med. Journal*, May, 1882.)

Credé of Dresden (*Deutsche Med. Wochen*, June 10th, 1882) reports a case of successful extirpation of the spleen for *cystic degeneration*. Patient was a male aged 24. Spleen removed through an abdominal incision. In 17 months patient left perfectly well. During convalescence no increase of size in the lymphatic glands could be detected, nor was there any disturbance in the marrow of the bones, but an inflammatory swelling of the thyroid gland occurred during the fourth month.—(*American Journal of the Medical Sciences*, Oct., 1882.)

Treatment of Tonsillitis.—Dr. Edward Mackey (*British Medical Journal*, Oct. 14th, 1882) thinks the treatment of tonsillitis by the salicylates is not so widely recognized as it should be. The value of this treatment was first pointed out by Mr. Hormazdji. He recommended twenty grain doses of the salicylate of soda. Dr. Mackey gives it in ten grain doses every two or three hours. In all the cases treated the pyrexia was much lessened and great relief experienced by the patient almost immediately after taking the remedy. Dr. Mackey also recommends a lotion of two drachms of salicylate of soda to eight ounces of water as a very efficient remedy for the severe pain of gouty joints.

Dr. E. Staver (*Phil. Med. News*, Nov. 18th, 1882) recommends the application of powdered bicarbonate of soda to the inflamed tonsils by means of an insufflator. The fever rapidly declines and with it the discomfort.

Dr. Henry describes (*New England Medical Monthly* for June) a number of cases of hypertrophy and ulceration of the tonsils which he has cured by the use of iodoform in the form of spray. He dissolves the iodoform in strong sulphuric ether. This he sprays on the tonsils by means of a spray producer of his own, having three tubes, one turned down, one straight and the other turned up. The posterior part of the tonsils is sprayed with the turned down tube.—(*London Medical Record*.)

Dr. Fraenkel (*Verhadl. der Berlin. Med. Gesellsch.*, Bd. xiii., p. 129), says *Catarrhal Angina* or *Tonsillitis Lacunaris* in the great majority of cases, subsides without treatment, so that our object can only be to shorten or render it less severe. The use of astringents, such as nitrate of silver, he considers

useless, as the disease lies mainly in the crypts of the tonsils, which the astringent does not reach. The same is true of gargles and of inhalations, while the former, in addition, frequently themselves cause unpleasant sensations in the throat. The use of emollients gives frequently much relief. Dr. Fraenkel has tried submucous injections of a carbolic acid solution, so as to be sure of reaching the crypts, but has seen no benefit from them, neither has he seen any good results from chlorate of potash, which is so often useful in stomatitis. Of guiacum, recommended strongly by Dr. Morell McKenzie, he has had no experience, nor has he had any experience of tincture of aconite, which last remedy he thinks has been borrowed from homœopathic sources by English physicians. Ice and cold applications are to many most grateful, while to others they are absolutely intolerable. For some months he has treated all his cases with quinine or salicylate of soda. Of 15 cases treated with large doses of quinine, not one has lasted longer than 48 hours, the usual average being two to five days. He gives three doses of about 4 grains of quinine within an hour at night. Although quinine shortens the disease, it does not in certain cases prevent peritonsillar abscess. The *rationale* of the action of quinine, Dr. Fraenkel does not pretend to understand.—(*London Medical Record*, Oct., 1882.)

Mr. Kenneth Millican (*London Lancet*, July, 1882) agrees with Dr. Atkinson's statement that *Tonsillitis* generally depends on two causes, great mental anxiety and irregular meals. Dr. Atkinson does not believe (*Lancet*, August 26th) that Acute *Tonsillitis* is the direct result of cold, but he has often found it associated with masturbation.

I have myself noticed that Acute *Tonsillitis* is occasionally seen in the newly married, and is connected in some way with sexual excitement. During the last two years I have had four cases of severe Acute *Tonsillitis* in newly married women and two cases in newly married men. Probably this cause would come under the head of Anxiety. There is perhaps, after all, truth in the old theory that there is some connection between the tonsils and the generative system.

The treatment I have found most successful is the application of an ice poultice around the neck and the administration of minim doses of aconite every two hours. Lately I have had good success with salicylate of soda, it often cuts short the disease and nearly always alleviates it.

Dr. Gordon Holmes, in article in *London Lancet* for Nov. 11th, 1882, on the *Treatment of Enlarged Tonsils*, recommends excision with Fahnstock's Tonsillotome. He does not recommend the operation in the acute stage, as he says it is by no means uncommon to see even mild cases of subacute or chronic tonsillitis in which a considerable swelling undergoes spontaneous involution in the course of a month or two. Such instances are very apt to mislead the practitioner into the belief that a cure has been wrought by the aid of some really impotent local application. "It is also," he says, "interesting to observe that in a series of such attacks where the subsequent involution is always less and less complete, we can perceive the origin of chronic tonsillar hypertrophy." He dissents from the theory that the removal of the tonsils has some adverse effect on the generative system.

If excision is objected to by the patient or his relatives, he recommends repeated cauterizations of the enlarged tonsils by the solid nitrate of silver or chloride of zinc. Thin pointed sticks of these should be pressed into the lacunæ, or orifices of the follicles, which are easily seen and are of large size in a hypertrophied gland. In this way we can attack the heart of the gland in a most efficacious manner. Small sloughs form, which are soon discharged and thus the tonsils are hollowed out in one direction while being contracted by subsequent cicatrization in another. Two or three channels in each tonsil can be cauterized daily or on alternate days, and thus a comparatively large surface can be acted on with very little suffering to the patient.

(To be continued.)

BI-MONTHLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Prof. Medical Jurisprudence and Hygiene, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

Extra-Uterine Pregnancy.—At the last meeting (in September.) of the American Gynecological Society, Dr. T. Gaillard Thomas read a paper entitled, “Notes on Twenty-one Cases of Extra-Uterine Pregnancy.” The author began by saying that until the last decade very little attention has been paid to the clinical study of extra-uterine pregnancy. In a general way it has received attention in works upon obstetrics, and the physiology and pathology of the subject have been carefully investigated, but its clinical bearings and collection of histories, and the careful collation and analysis of the symptoms which should arouse the fear and suspicion of the practitioner, and give the most appropriate treatment, had received an amount of attention entirely incommensurate with their paramount importance.

For the pathologist there were many varieties, but for the practitioner there are naturally but three, namely, tubal, interstitial, and abdominal. The history of twenty-one cases which had fallen under his observation was then briefly given. The symptoms which most frequently led to diagnosis were the symptoms of normal pregnancy accompanied by: 1st, regular gushes of blood ceasing and suddenly recurring without assignable cause; 2nd, fixed grinding pain in one iliac fossa, and perhaps down the corresponding thigh; 3rd, paroxysmal pains occurring with severity, marked by constitutional symptoms and in a short time passing off, to recur with increased violence in a few days; 4th, symptoms of abortion without an appearance of the foetus; 5th, expulsion of membranes without accompanying foetus.

The physical signs which sustained the validity of these symptoms were: 1st, Increased size in the uterus and displacement of it upwards, forwards, and laterally; 2nd, evidence of vacuity in it, yielded by the sound or tube; 3rd, the presence either to

one side of the uterus or behind it of a cystic tumor somewhat painful to the touch, rather immovable, giving to palpation a sense of rather obscure fluctuation, and in some cases yielding the sign of "ballotement". In a few of his cases this sign has been plainly distinguishable, but this had been an exception to the rule, and the absence of it should never be relied upon as evidence against the existence of the condition. In cases of advanced gestation of the ectopic variety, the placental murmur, the foetal heart, and the movements of the foetus will of course present themselves as valuable signs; but in tubal pregnancy, the kind most commonly encountered, death will generally occur from rupture of the foetal nest before they become at all available.

As to treatment, he proposed simply to give rules which he thought his experience would induce him to adopt in future.

First. If an ectopic tumor be discovered and its nature pretty well settled before the end of the fourth month of gestation, he would destroy the vitality of the child by electricity in preference to all other methods which have been proposed.

Second. Should the fourth month of gestation be passed and surgical interference be called for, laparotomy or, if the tumor be low down in the pelvis, elyrotomy should be preferred to the use of electricity, which leaves a large foetal body to undergo absorption inside the body of the mother.

Third. Should the pregnancy be abdominal, the practitioner should wait and watch, if possible, until nature demonstrates the outlet by which she desires the extrusion to be effected, then she should be aided. If, on the other hand, bad symptoms, under these circumstances, at any time showed themselves, laparotomy under strict antiseptic precautions, should be promptly resorted to.

Fourth. Should rupture of the foetal nidus have occurred before diagnosis has been fully made, the practitioner should wait and see whether nature is powerful enough to overcome the shock and control hemorrhage, then, further, if the patient is going to escape the dangers of peritonitis and septicæmia. If these favorable results do not occur, if hemorrhage is about to destroy the patient immediately, or if septicæmia attacks her

later, laparotomy, followed by antiseptic cleansing, should be promptly adopted.

Why is *Chloroform safer in Midwifery* than general practice? The fact is generally known, but we do not remember having seen until now a good reason adduced. The immunity from accident is not absolute. Dr. Lusk believes that it is due to greater caution in administration. He narrowly escaped losing a patient in Bellevue Hospital on whom he designed to perform version, in consequence of his house-physician suddenly crowding a paper funnel containing a towel wet with chloroform over the mouth and nose.—(*Am. Jour. of Obst.*, Oct., '82.)

Dr. Fancourt Barnes, in a note in the *British Medical Journal*, Oct. 21st, 1882, expresses his belief that the greater safety is due to the condition of the heart and vascular system during pregnancy. The heart becomes hypertrophied, the venous system becomes enlarged by the distension of existing veins and the development of fresh venules. The quantity of blood is increased. When chloroform produces fatal syncope, it does so by its depressing action on the heart. The weaker the heart, the more readily does it succumb to the paralyzing action of chloroform. The hypertrophied heart of pregnancy more readily withstands the action of chloroform. Mr. S. E. Burton, F.R.C.P., of the London Hospital, believes that another important factor comes into play in these cases—viz., the absence of the depressing, and even paralyzing influence of fear. In an ordinary operation, the patient approaches with dread; and numerous instances are on record in which fear alone has brought about fatal syncope, even before the further depressing effects of chloroform have had time to take effect—even before its administration has been begun. In confinements the case is different. The patient is already in great pain; the heart is acting powerfully, in consequence of great muscular exertion; and, instead of looking forward to the chloroform with dread as the antecedent to a dangerous operation, she actually desires it as a relief to present suffering. She is thus in the most favorable condition possible for its administration, and, even if there were no cardiac hypertrophy, we might expect an almost total immunity from fatalities from the use of chloroform in these cases.

A New Sign of Pregnancy.—Jorissenne, in an article in the *Archives de Tocologie*, June, 1882, indicates what he believes to be a valuable diagnostic sign for pregnancy during the first two months. We have hitherto had no unequivocal sign of early pregnancy. He has found that whilst in health there is a variation of from ten to twenty beats in the radial pulsation, according as the body is upright or horizontal, in pregnancy, no matter what the position, the beats number the same. The author has been able to diagnosticate pregnancy as early as the first month, when no other sign except the missing of the menstrual period was present. When examining a patient for this sign, it is necessary to proceed with deliberation, first counting the radial for the space of fifteen seconds whilst the patient is standing, then sitting, then reclining. The order may then be reversed, and uniformly the same number of beats will be recorded.

The Treatment of Placenta Prævia.—Hofmeier, assistant physician at the Berlin University Obstetrical Clinic, has an article on this subject in the *Zeitschrift f. Geb. u Gynäkologie*, Bd. VIII., Hft. 1. At the outset of his paper the author justly remarks that there is no obstetrical subject the literature of which is so rich as this. His conclusions and methods claim our attention on account of the excellence of his results. His material consisted of 46 cases, 35 of which were delivered in one year, thus offering an excellent chance to judge of a method carried out by one man in so many cases. In judging of his method, he first excluded from the 46 cases 3 who were so far gone from hemorrhage when he arrived that there was no chance for any treatment. Of the remaining 43, in 19 the location of the placenta was central, in 16 lateral, and in 8 marginal—a very large percentage of central. The usual rule of treatment is to tampon until the cervix is sufficiently dilated. *This* rule the author opposes. He scarcely ever uses a tampon, and as to the cervix, his rule is only to wait till clear symptoms of labour set in, either in uterine contractions or a funnel-shaped dilatation of the cervix. He then proceeds as actively and early as possible. This rule was followed in 37 of the 43 cases, after poor experience in other methods with the rest. In 19 the cervix was partially or wholly dilated; in 18, either entirely closed or with only a funnel-shaped

dilatation. The earlier the operation the more of necessity is the choice limited to the combined external and vaginal version with one or two fingers, the Wigand-Braxton-Hicks method. This was done in 30 cases, the foot was brought down in three breech cases, three times internal version was performed, and once the forceps applied. The combined turning was practised whenever possible, and the hand introduced into the uterus only when absolutely necessary. The feet having been guided to the os, are seized, and by firm traction the buttocks effectually stop the hemorrhage. In cases of central position of the placenta, the author, in spite of all the arguments against it, is in favour of perforating the placenta, and bringing the feet through. He did it in five cases, in three of which it was necessary on account of haste, and in two of which the child was already dead. It gives the mother the best chance, and the child's chance is by any method in such a case extremely small. The rest of the delivery, the author expressly stated, should be slowly accomplished. The condition of the child may modify this rule, but even this must not make us increase the mother's risk. One must have the courage to let a doubtful child's life be lost in his hands, rather than subject the mother to increased danger. The child is to be delivered slowly. Even so, the author's results were not bad as regards the children. Of 37, 17 were already dead; of the 20 still living, 6 died (3 premature and 3 from perforation of the placenta). Altogether, 63 per cent. died and 37 per cent. lived, which is up to the usual standard.

The statistics of the mothers, however, are very much better. The author considers in them not only the immediate result, but the aftercourse of the case. In each case ergotin was given subcutaneously during extraction, and the uterus washed out afterwards with a 5 per cent carbolic solution. Of the 37 patients treated by these rules, *one* died. She had been treated for 24 hours by tampon, and the placenta was foul and offensive when the delivery took place, and she died 17 days after from phlegmon and phlebitis of the thigh. He believes she would have surely been saved if action had been prompter. This one case out of 37 gives a mortality rate of 2.7 per cent., and 40 per cent. after-

hemorrhages occurred in some cases, but none which could not be controlled with ergotin, iced and hot water injections. Of the six cases treated at an earlier date, and by the *waiting* method, one died, and two had a long, severe lying-in; four children were dead. Of the whole 46 cases, therefore, 5 died; 10.8 per cent. The author adds two useful hints as to the location of the placenta. In nearly central location, the smaller portion is the one which is more loosened from the cervix lip. In placenta previa lateralis, the proportion in favour of the right side is about 11.4.

A Modified Procedure in the Operation of Cæsarean Section.—This is the title of an article in the *Archiv für Gynakologie*, Bd. xix., vol. 2; (an abstract of same in *Centralblatt für Gynakologie*, No. 33, 1882.) In this paper the author, after referring to the various methods recommended in the performance of this operation, including Porro's method, states that the results of them all hitherto, notwithstanding the antiseptic system, are extremely unsatisfactory. He then formulated under three heads the objects required to render the operation as successful as possible: 1st, Section of the uterine muscle at the spot where it is least inclined to gape; 2nd, a reliable method of suture; 3rd, the strictest antiseptic measures during the operation, with removal and disinfection of the peritoneal exudations and of the lochia after the operation. To secure the first point, Kehrer recommends to make the incision transversely in the anterior circumference of the inner os, which is, on an average, a centimetre above the bottom of the vesico-uterine pouch. The tendency to gape is here very little, and it is further opposed in a powerful manner by the normal position of the ante-version after delivery during the childbed period.

In favor of this position for the incision, the author urges further that in this situation the placenta is rarely met with, whilst the head usually lies there, and thus early breathing of the foetus is facilitated. In regard to sutures, Kehrer recommends the adoption of a double suture—one deep uniting the muscular wall, and one superficial to secure the co-aptation of the peritoneal surfaces. As to the third, the strictest antiseptic

arrangements are employed both before and during the operation. The vagina is thoroughly disinfected before the operation, the interior of the uterus is thoroughly irrigated by a carbolic solution and rubbed in with a carbolized sponge, whilst the peritoneal cavity is scrupulously cleansed. For maintaining subsequent drainage, Kehrer expresses himself in favor of several drainage tubes for the peritoneal cavity, but opposed to carrying a single drain through the abdominal wound, uterus and vagina. The drainage tubes should be so disposed that two small tubes should lie on the two sides of the vesico-uterine pouch, and a third larger, and longer, pass over the uterus into the pouch of Douglas. The paper ends with the records of two cases, one of which recovered, the child's life being saved also. In the second case the patient died. Both cases were for high deformity due to osteomalacia.

One thousand consecutive cases of Ovariectomy performed without any of the Listerian Details, by Mr. Lawson Tait.—This was the title of a paper read by Mr. Tait before the last meeting of the British Medical Association. There were only three deaths, one by accidental suffocation, it ought not therefore to be reckoned in the mortality of the operation. Six of the patients were pregnant at the time of operation. In one of these there was acute peritonitis at the time of the operation. All of these six pregnant patients recovered and had their children afterwards with one exception; she miscarried on the second day after operation and then made an easy recovery; four in all of the patients suffered from acute peritonitis at the time of operation. In two cases the disease was solid fibroma of the left ovary, in the other ninety-eight the disease was cystoma; of these the disease was in eleven cases parovarian, the ovaries and fallopian tubes were left intact, so that the operation was not ovariectomy at all. Mr. Tait has, however, included them, as Mr. Spencer Wells has done, and as everybody must do, who wishes to contrast with him. The proportion here given bears out Mr. Tait's previous estimate that parovarian cysts constitute about 10 per cent. of such operations. The presence of adhesions did not add in any way to the mortality. The operator attributes his remarkable success in this series of cases chiefly

to the abandonment of the clamp (Mr. Spencer Wells's) treatment of the pedicle; the adoption of Keith's and Kœberle's method of cleansing the peritoneum. Increased personal experience diminished proportion of cases that had been frequently tapped; complete abandonment of the use of carbolic acid, or any other so-called antiseptic system, in the performance of the operation, and in the subsequent treatment; the establishment of hospital discipline and hygiene, on the best known principles, for private as well as for public patients. Mr. Tait appends a table, giving the date of operation, the age, and residence of each patient, and the name of her ordinary medical attendant apparently with the object of preventing the making of unfair and unwarranted statements behind his back, statements no one was bold enough to make in public. Mr. Tait stated that in the instance of one well-known surgeon he had to resort to the extreme measure of a threat of legal proceedings, and that he certainly would carry the threat into execution if this kind of criticism were continued—(*Brit Med. Journal*, Oct. 28, 1882.)

Vaginal Lithotomy.—At the regular meeting of the New York Obstetrical Society, on the 16th of May last, Dr. Watts showed a vesical calculus which he had removed from a woman aged 55, who entered the Roosevelt Hospital, complaining of falling of the womb, the perineum was badly torn and there was prolapsus of the rectal and bladder walls. On examining per vaginam, a hard mass could be felt through the vesical walls, she had symptoms of severe cystitis, having to pass water every few minutes, and being unable to walk. A long incision was made through the vesico-vaginal septum, and the stone was removed. The incision was closed, a catheter was introduced into the bladder, and all went well, pain being relieved, until the ninth day, when leakage took place through a small point in the line of incision, though sloughing was more extensive on the vaginal edges of the wound. Cleanliness was observed; after ten days the leakage ceased, and the patient went on to complete recovery, all her former symptoms having disappeared. Drs. Pallen and Lee took part in the discussion which followed; both gentlemen commended the practice so ably advocated by

Emmet, of leaving the wound open to facilitate the cure of the cystitis which is always present to some extent with calculus. The removal of vesical calculi by this method in preference to that through the urethra is I am happy to say becoming general. A vesico-vaginal fistula thus produced by operation can always be cured, but dilatation of the urethra for removal of calculus has often been followed by permanent incurable incontinence. (*Supplement to the American Journal of Obstetrics*, Nov. 1882).

(*To be continued.*)

Reviews and Notices of Books.

A System of Human Anatomy, including its Medical and Surgical Relations.—By Harrison Allen, M.D., Professor of Physiology in the University of Pennsylvania. Section I.—Histology. Section II.—Bones and Joints. Philadelphia: Henry C. Lea's Son & Co.

The first two parts of this long looked-for work have been issued, and we may judge in some measure from them what the prospects are for a standard American work on Anatomy. Active as our neighbours are in issuing medical publications, no native treatise in anatomy of any pretension exists, and this attempt of Prof. Allen to supply such a deficiency, to remove such a reproach, is in the highest degree commendable. He has had, moreover, the necessary training and experience for that task, and in both human and comparative anatomy enjoys the reputation of an able teacher and an original worker. The first section, on Histology, is by Dr. Shakespeare, and comprises nearly 100 double-column quarto pages—12 plates and 63 woodcuts in the text. This part shows careful preparation, and gives a full exposition of the minute anatomy of the tissues. A larger number of original figures would have been an improvement; we are sure Dr. Shakespeare could have furnished them. Section II., Bones and Joints, brings us into the author's company, and we must confess to having spent several pleasant and profitable hours with him. The bones, indeed, are dry, but he clothes them and endows them with vitality and interest by regarding them as much

from the standpoint of the practitioner as the anatomist. This we consider the chief feature of the work, and the one which gives it special value, as in no other work that we know of is the same amount of valuable and suggestive information given. Take, for instance, the inferior maxilla : a page suffices for the technical description, while nearly four pages are devoted to practical considerations, in which the various surgical and pathological conditions of the bone are enumerated in relation to the anatomical structure. In each instance, in the remarks which follow the systematic account, the attention is directed to points of medical or surgical interest. A very useful section is that on the identification of bones for medico-legal purposes, which contains information not often met with either in anatomical or medico-legal works. The plates are, as a rule, well executed and clear, and have the name of each part engraved on the figures. Some of them are a trifle coarse, but, on the whole, they compare favourably with those in other large anatomical works. We have said enough to show our appreciation of the undertaking, one involving immense labour on the part of the author, but, when completed, we feel sure that the position it will take in the profession will more than recompense him, and we shall now have to add to the standard works of Henle, Hyrtl, Sappey, Quain and Grey, that of Allen.

A Guide to Therapeutics and Materia Medica.—
By ROBERT FARQUHARSON, M.D., Edin., L.R.C.P., Lond.,
late Lecturer on Materia Medica at St. Mary's Hospital
Medical School. Third American edition, revised by the
author. Enlarged and adapted to the U.S. Pharmacopœia
by FRANK WOODBURY, M.D., Physician to the General
Hospital, Philadelphia. Philadelphia : Henry C. Lea's
Son & Co. Montreal : Dawson Bros.

It is by no means surprising that Dr. Farquharson's *Therapeutics* has already reached a third edition in the United States. It is constructed upon a plan which brings before the reader all the essential points with reference to the properties of drugs—impresses these upon him in such a way as to enable him to take

a clear view of the actions of medicines and the disordered conditions in which they must prove useful. His double-columned pages—one side containing the recognized physiological action of the medicine, and the other the diseases in which observers, (who are nearly always mentioned), have obtained from it good results—is a very good arrangement. The early chapter containing rules for prescribing is excellent, and will repay perusal to every one beginning to take charge of patients. We have much pleasure in once more drawing attention to this valuable and well-digested book, and predict for it a continued successful career.

Practical Laboratory Course in Medical Chemistry.

By JOHN C. DRAPER, M.D., LL.D., Professor of Chemistry in the Medical Department, University of New York, and of Physiology and Natural History in the College of the City of New York. New York: Wm. Wood & Co.

This is an excellent handy manual for the use of students in the chemical laboratory. It is systematically arranged and presented in a very convenient form, alternate pages remaining blank for notes required at the various sections. It is divided into four sections. I.—Poisons, organic and inorganic. II.—Water. III.—Animal Fluids. IV.—Sediments and Calculi. The directions for examination and analysis are all given in short paragraphs, numbered for easy reference. We have no doubt it will prove a useful guide, and will be appreciated both by teachers and students.

The Multum in Parvo Reference and Dose Book.—

By C. HENRI LEONARD, M.A., M.D., Professor of the Medical and Surgical Diseases of Women and Clinical Gynæcology, Michigan College of Medicine. Detroit: The Illustrated Medical Journal Co.

A very cheap little book—30 cents—containing a variety of information on different subjects. New remedies and preparations, doses of medicines, incompatibles, poisons and antidotes, tests, obstetric memoranda, visceral measurements, &c. Dr. Leonard

has had much experience in compiling condensations of this kind, and this one no doubt will be found a useful companion.

What to do in Cases of Poisoning.—By WM. MURRELL, M.D., M.R.C.P., Lecturer on Materia Medica and Therapeutics at the Westminster Hospital, Assistant Physician to the Royal Hospital for Diseases of the Chest. Second edition. Detroit: Geo. S. Davis.

This is a little vest-pocket book which will be found a most useful and reliable remembrancer. It is written by one of the best-known practical experimenters with drugs, and contains short directions for the treatment of poisoning by almost all the known hurtful medicinal agents, or those used in the arts and trades. It is just what every one should have by him for use in emergencies.

The Physician's Visiting List for 1883.—Thirty-second year of its publication. Philadelphia: P. Blakiston, Son & Co.

The arrival of the annual Visiting List is one of the indications that another year is nearly done, and that the physician must provide himself with a new almanac for the coming one. Blakiston's list is perhaps more widely known and used than any other. It is as neatly gotten up, as compact, as well printed, and furnished with as good paper as it always is. We only need to notice its reception so as to call our readers' attention to it, so that they may furnish themselves with what has come to be an essential part of the doctor's outfit.

Books and Pamphlets Received.

MEDICAL ELECTRICITY, A PRACTICAL TREATISE ON THE APPLICATION OF ELECTRICITY TO MEDICINE AND SURGERY. By Roberts Bartholow, A.M., M.D., LL.D. Second edition enlarged and improved, with one hundred and one illustrations. Philadelphia: Henry C. Lea's Son & Co.

THE DISEASES OF THE LIVER, WITH AND WITHOUT JAUNDICE; WITH THE SPECIAL APPLICATION OF PHYSIOLOGICAL CHEMISTRY TO THEIR DIAGNOSIS AND TREATMENT. By George Harley, M.D., F.R.S. Philadelphia: P. Blakiston Son & Co.; Montreal, Dawson Bros.

QUIZ-COMPENDS, No. 1., QUESTIONS ON HUMAN ANATOMY. By Samuel O. Potter, M.A., M.D. Philadelphia: P. Blakiston Son & Co.; Montreal, Dawson Bros.

ON SLIGHT AILMENTS, THEIR NATURE AND TREATMENT. By Lionel S. Beale, M.D., F.R.S. Second edition. Philadelphia: P. Blakiston Son & Co. Montreal, Dawson Bros.

THE ILLUSTRATED QUARTERLY OF MEDICINE AND SURGERY. Edited by Geo. Henry Fox and Frederic R. Sturgis. Vol. 1, No. 4. New York: E. B. Treat.

THE SYMPATHETIC DISEASES OF THE EYE. By Ludwig Mauthner, M.D., translated from the German by Warren Webster, M.D., and James A. Spalding, M.D. New York: Wm. Wood & Co.

LECTURES ON ELECTRICITY IN ITS RELATIONS TO MEDICINE AND SURGERY. By A. D. Rockwell, A.M., M.D. New York: Wm. Wood & Co.

AN INDEX OF SURGERY: BEING A CONCISE CLASSIFICATION OF THE MAIN FACTS AND THEORIES OF SURGERY FOR THE USE OF SENIOR STUDENTS AND OTHERS. By C. B. Keetley, F.R.C.S. New York: Wm. Wood & Co.

THE INCIDENTAL EFFECTS OF DRUGS, A PHARMACOLOGICAL AND CLINICAL HANDBOOK. By Dr. L. Lewin, translated by W. T. Alexander, M.D. New York: Wm. Wood & Co.

DISEASES OF THE RECTUM AND ANUS. By Charles B. Kelsey, M.D. New York: Wm. Wood & Co.

MATERIA MEDICA AND THERAPEUTICS, (INORGANIC SUBSTANCES). By Charles D. F. Phillips, M.D. New York: Wm. Wood & Co. Vols. I and II.

THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY. A systematic treatise on the theory and practice of Surgery by authors of various nations. Edited by John Ashurst, Jr., M.D. In six months, Vols I and II. New York: Wm. Wood & Co.

THE STUDENTS MANUAL OF VENEREAL DISEASE, BEING A CONCISE DESCRIPTION OF THESE AFFECTIONS AND OF THEIR TREATMENT. By Berkeley Hill and Arthur Cooper. Second Edition. New York: Wm. Wood & Co.

SUPPRESSION OF URINE, CLINICAL DESCRIPTIONS AND ANALYSIS OF SYMPTOMS. By E. P. Fowler, M.D. New York; Wm. Wood & Co.

A CLINICAL HANDBOOK OF THE DISEASES OF WOMEN. By W. Symington Brown, M.D. New York: Wm. Wood & Co.

A TREATISE ON DISEASES OF THE EYE. By Henry D. Noyes, A.M., M.D. New York: Wm. Wood & Co.

A HANDBOOK OF UTERINE THERAPEUTICS, AND OF DISEASES OF WOMEN. By Edward John Tilt, M.D. New York: Wm. Wood & Co.

LECTURES ON DISEASES OF CHILDREN. By Dr. Edward Henoch. New York: Wm. Wood & Co.

ON ASTHMA, ITS PATHOLOGY AND TREATMENT. By Henry Hyde Salter, M.D., F.R.S. New York: Wm. Wood & Co.

ARTIFICIAL ANÆSTHESIA AND ANÆSTHETICS. By Henry M. Lyman, A.M., M.D. New York: Wm. Wood & Co.

A TREATISE ON FOOD AND DIETETICS, PHYSIOLOGICALLY AND THERAPEUTICALLY CONSIDERED. By F. W. Pavy, M.D., F.R.S. New York: Wm. Wood & Co.

PRACTICAL MEDICAL ANATOMY: A guide to the Physician in the study of the relations of the viscera to each other in health and disease. By Ambrose L. Ranney, A.M., M.D. New York: Wm. Wood & Co.

MENTAL PATHOLOGY AND THERAPEUTICS. By W. Griesinger, M.D. Translated from the German by C. Lockhart Robertson, M.D., Cantab, and James Rutherford, M.D., Edin. New York: Wm. Wood & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Oct. 20th, 1882.

R. A. KENNEDY, M.D., PRESIDENT, IN THE CHAIR.

Pathological Specimens.—Dr. Osler exhibited the following specimens :—

1st. A specimen from a case of fatty diarrhoea, sent by Dr. Wolverton, of Hamilton. A woman *æt*, 30 had suffered for some weeks with gastro-intestinal disturbance, and for the past two weeks the dejections contained a remarkable amount of fat. Dr. Wolverton has promised a full report of the case.

2nd. A portion of the paunch of a cow presenting numerous examples of "Amphistoma Conicum," a fluke not uncommon in this region in "Ruminants." It would appear to be particularly abundant in the animals in Pictou County, N.S.

3rd. Specimens of obliterated superior vena cava from a patient of Dr. Wilkins, who had been in the hospital some twelve weeks with symptoms of venous obstruction in the thorax, lividity and swelling of face and upper extremities, with attacks of intense dyspnoea. Constantly accumulating effusions occurred into the left pleural cavity, necessitating frequent tapplings. The superior cava was obliterated in its entire length and converted into a firm fibrous cord, about the thickness of the thumb. The internal jugulars and innominate contained fine thrombi undergoing fibroid transformation. Between the ascending aorta and the right lung there was a good deal of cicatricial tissue covering over and surrounding the obliterated vein. No heart disease or other lesion found.

4th. Specimen of a case of pneumonia terminating in abscess of the lung. The patient was under care of Dr. Molson in the hospital, a very intemperate woman aged 35, brought to hospital on the 4th day from onset of a severe pneumonia of the left lung, following a heavy drinking bout. On the 10th day she spat up large quantities of stinking purulent matter, and at the same time the temperature, which had remained about 104°, fell to 99°. She died on the following day.

Dr. Osler then exhibited some eighteen ounces of bile, obtained by aspirating the gall bladder of a patient, having the following history :

C. M. S., æt. 58. farmer, of fairly good health, with phthisical history on mother's side. In the month of April last first felt pain in back and shoulders and across the kidneys, did his spring work and did not consult any doctor. Early in June he noticed his water was dark, and his face became jaundiced and deeper than at present. Never had any paroxysmal pain, but pain was of a dull heavy character ; no vomiting, lost much flesh in last two months, clay-colored stools, great itchiness, sleepless, appetite good. Present condition : Well-preserved man, not very grey, skin jaundiced, walks bent because of pain, conjunctivæ stained, tongue clean, breath not bad, abdomen flat, a little prominent in right hypochondriac region ; liver dullness greatly increased, and a rounded mass is felt on right side of abdomen, corresponding to upper half of area of increased dullness, movable, elastic and evidently connected with the liver ; surface of liver below costal border not roughened, a little tender below xyphoid cartilage. The distended gall bladder was aspirated, and about 18 ozs. bile removed, but without much benefit ; nature of obstruction not quite clear ; no history of gall stone.

Dr. Bell exhibited a bladder in a state of phlegmonous inflammation from a patient who died in the hospital from the effects of fracture of the spine.

Dr. Shepherd exhibited two femora which belonged to an old woman æt. between 80 and 90 years, the subject of general "Fragilitas Ossium," or senile atrophy of bones. The left femur had the characteristic deformity of osteo-arthritis, the neck being shortened and the head enlarged ; the acetabulum of that side was much enlarged also. In this femur there was an old united fracture just above the condyles. In the right femur there was an ununited intracapsular fracture. Dr. Shepherd remarked that all the bones presented the atrophic condition, the skull cap in particular, being only of parchment thickness. The astragalus could be easily broken down between

the finger and thumb ; very slight accidents in these cases are liable to produce fracture.

Cancer of Œsophagus.—The next specimen was exhibited by Dr. Geo. Ross, who also made a few remarks on the history of the case. The patient from whom the specimen was taken, J. M., æt. 54, was admitted into the General Hospital Oct. 10th, 1882, complaining of cough, pain in epigastric region and weakness. In May had pain in midsternum and to the left side. In June had frequent vomiting ; after a time solids seemed to be stopped on the way down, to roll about in his stomach, and then would be at once brought up. Has lived on soft toast, tea, and milk for a long time. Has been intemperate. Began to cough three weeks ago, and soon noticed a very foul smell coming up his throat with the cough.

Status Præsens—Anæmic and emaciated, pulse weak ; sharp bubbling sounds heard at base of right lung to spine of scapula and into the axilla. Expectoration serous with purulent masses, faint fetid odor. Liver felt greatly enlarged, smooth and very little tender. A large-sized bougie was passed readily into the stomach, no obstruction ; was made to swallow dry bread, which he did well. In spite of the negative signs given by the passage of the bougie the case was considered to be one of cancer of œsophagus with secondary affection of lung, and fatty or cancerous liver.

Post Mortem.—The œsophagus presented an enormous cancerous ulcer situated in its lower half, extending for about four inches and involving nearly the whole circumference of the tube with the exception of a narrow tube-like portion on the posterior wall. The edges were swollen and infiltrated, and the base presented a deep excavation which at the right margin had perforated the lung, and formed near the root a series of sloughy abscesses in an area about the size of an orange ; there were extensive secondary masses in the liver, particularly in the left lobe.

Remarks on Specimens Exhibited.—Dr. Mills, in cases of cancer of œsophagus, thought the passage of the bougie might be explained by a peculiar turn of the instrument ; he thought

it would have been a good case for auscultation of the œsophagus. Dr. Ross, on the other hand, thought auscultation would have also failed inasmuch as there was no obstruction; he thought œsophagoscopy would have been more serviceable. Dr. Mills then explained the mechanism of Morrell Mackenzie's apparatus for œsophagoscopy. He did not agree with Dr. Ross in regard to auscultation, the œsophagus being a closed tube. Although no obstructions were present its walls were so diseased that they could not act muscularly, and thus, in swallowing, the sounds would be delayed sufficiently to be appreciated by means of the stethoscope. Dr. Osler also agreed with the last speaker; he had had some experience in œsophageal auscultation in the Vienna Clinique, and the difference in the sounds was very marked. Dr. Henry Howard, speaking in regard to the bones exhibited by Dr. Shepherd, remarked that such a condition was frequently found in aged persons of unsound mind, and accidents were frequently occurring in lunatic asylums from very slight causes, owing to this fact.

Dr. Roddick reported a case of laceration of the left kidney, followed by death on the fourth day. The case occurred in the practice of Dr. Simpson, with whom he had seen the patient in consultation. The patient, a woman of sixty years, but remarkably healthy and vigorous, fell accidentally from the top to the bottom of a long stairway, and was picked up in an insensible condition. There was no wound to be found, but she complained from the first of great pain in the right loin. Vomiting soon began, and, in spite of all treatment, continued to the end. The bowels became tympanitic, and refused to act. The most marked symptom, however, was the passage of pure blood from the bladder. This formed a large clot in the vessel, and urine was for some hours almost absent. The urine after the first twenty-four hours became more and more smoky, until, on the fourth day, it was almost bloodless. Rupture of the kidney was diagnosed, and, on account of the obstinate condition of the bowels, ileus was suspected, although no tumor could be felt. The long O'Beirne's tube was passed, and a large injection thrown into the bowel, but with no effect. At the autopsy a

large clot of blood was found surrounding the right kidney, and a rent through the border of the organ, communicating with the pelvis, whence the blood evidently came. The kidneys were slightly granular. The bowels were found unobstructed, although it was thought that the blood clot might have pressed unduly on the ascending colon, and interfered with its functions.

Clinical Notes on Hæmatemesis in Chronic Splenic Tumors.

—This paper was read by Dr. Osler. (See page 267.)

Discussion on Paper.—Dr. Buller asked for information as to the supposed possible cause of hæmorrhage in these cases, if mechanical or due to condition of blood. Dr. Osler replied that in some cases it would seem to be due perhaps to a feeble condition of the vessels as in leucocythemia and pernicious anæmia. In the cases under notice it might be explained by mechanical causes, considering that three-fourths of the blood from the stomach is discharged into the splenic vein, and in engorgement of the latter a sweating or diapedesis might be conceived as occurring from the vessels of the stomach.

Dr. Ross spoke of the obscurity connected with such accidents occurring under such peculiar circumstances, and the exact condition giving rise to them. In the early stages of cirrhosis we also have profuse hæmorrhages, and possibly the cases are of a parallel nature; probably other conditions have something to do with it. The great depression in mind spoken of in connection with one of the cases might have influenced the nerve supply of the blood vessels, allowing more or less dilatation of the splenic vein and damming back the blood into the gastric veins.

In reply to a question by the President, Dr. Osler said that he had used injections of ergotine, but could not say with much benefit.

Dr. Stephen remarked that in a recent number of the *Lancet* injections into the substance of the spleen had been condemned as being dangerous and inadvisable.

Dr. F. W. Campbell thought that something would be required to act more quickly than ergotine, and suggested that

the application of the ice-bag to the pit of the stomach would be especially good.

Stated Meeting, November 3rd, 1882.

R. A. KENNEDY, M.D., PRESIDENT IN THE CHAIR.

Dr. Major read a paper on papillomatous growths of the larynx, reporting two cases of simple papilloma, one of warty growth, in a case of rapid tuberculosis, and one of warty growths of the velum palati.

Discussion on Paper.—Dr. Osler, in reply to Dr. Major in regard to the pathology of papilloma of the vocal cords, said he did not think it differed from ordinary papilloma of other regions; those of the larynx seemed to be abnormal growths of the epithelial layers. He asked Dr. Major if it were possible to distinguish this growth from an epithelioma, and whether it ever passed into an epithelioma.

Dr. Roddick in speaking of the operation referred to by Dr. Major, at which he assisted, expressed his pleasure at the skillful manner in which the tumor was removed, although not unattended with difficulty, the tumor being he thought larger than it appeared by the laryngoscope, and at one time the patient being in a very alarming condition. He asked Dr. Major why he did not remove growths by opening the thyroid cartilages, and if it would not be preferable to have permanent aphonia than necessitating the continual carrying of a tube.

Dr. Mills said growths of this kind and their removal were very debatable subjects. Morrell McKenzie prefers their removal, and by evulsion, while Lennox Brown says that benign growths often become malignant even when well removed, whereas McKenzie does not think so. He thought from his experience that they are of more frequent occurrence than Dr. Major had shown. Malignant disease cannot be diagnosed if you rely on ordinary signs, as the glands, cachexia and pain. He thought it a mistake after the removal of such growths to allow the patient to return home, as subsequent cauterizations are always advisable. Evulsion he considered as not being

always practicable. He also spoke of the advisability of educating the throat not only by the physician but also by the patient to render skilful examination practicable. In all cases of aphonia careful examination of the throat should be made early. He would object to thyrotomy unless to save life.

Dr. Major in reply said it was exceedingly difficult to diagnose between the epithelioma and papilloma, as a rule time and history alone will decide. In this case thyrotomy was thought of, but the hope that the growths would ultimately disappear led him to put it off. And as a rule the tracheotomy tube is well borne.

A Proposed Vaccine Institute.—Dr. Bessey read a paper on this subject. He commenced by referring to the history of animal vaccination in Canada, the first attempt towards which was in the year 1875 in this city, but which for some reason or other was in a short time abandoned, and about the same time in a town in Ontario an attempt was made to furnish animal virus to the profession, but it also was soon discontinued. In 1877 a spontaneous epidemic of cow-pox having occurred at Longue Pointe, Dr. Bessey was afforded opportunity of procuring abundance of lymph, which he continued to furnish to the Montreal Board of Health for two years. In 1880 an allowance of twenty dollars per month was voted by the Board as a permanent subsidy to defray the expenses incurred in keeping the animals required, Dr. Bessey agreeing to furnish the Board (for the use of the public vaccinators) from time to time with such an amount of lymph as experience showed was necessary, each vaccinator being charged to collect the lymph from his first vaccinations to continue the service until the distribution of the next supply. An estimate given of the numbers vaccinated during the years 1878, '79, '80 and '81, compared with the average birth rate and allowing 25 per cent. to be deducted for death rate, shewed that there must remain a large number still unprotected. In the year 1872 there were 872 deaths from small-pox, and in the four following years 728, 647, 590, and 704 respectively. Prior to 1877, when animal vaccination was introduced, public opinion in certain quarters had been

very strong against general vaccination, till the people becoming convinced of its safety began to submit very generally to the operation, after which the prevalence of small-pox began to decline, and has finally disappeared altogether. The deaths in 1877 amounted to 506 and in 1878, 728, in 1879, 472; in 1880, 140; in 1881 only 5 deaths occurred, and this year there have been no deaths so far. It had been found by experience that lymph one or two removes from the animal gave the most perfect results; and while animal vaccine guarantees against the transmission of syphilis (which has been shown by well-authenticated cases to occur with the use of humanized lymph, however rarely), and while it is believed to afford perfect immunity from attacks of small-pox, yet it is the experience of many that frequently there is difficulty in making preserved vaccine "take" on the human subject, the average number of successes being about 80 per cent., whereas those of the 1st human remove average 98 per cent. This difficulty the reader of the paper thought could be removed by: 1st. An ample and constant daily supply; 2nd. Its careful preservation or immediate use; and, 3rd. The establishment of a national vaccine institute. Dr. Bessey stated that in the United States lately serious consequences had followed the use of so-called vaccine lymph furnished from some 14 vaccine farms, which fact, on investigation, was found to be due to the want of skill on the part of those employed in its collection. For some time past Dr. Bessey has been striving for the establishment of such an institution as the one proposed, and many petitions have been sent to the Government, but without receiving much more than a bare recognition, until, lately, the Joly Government offered ten acres of the Government farms at the Tanneries in perpetuity, but they had no money to put buildings thereon. More recently the Chapeau Government signified its willingness to vote a small annual subsidy, and also continue Mr. Joly's offer, provided the Dominion Government would build, or aid in putting up the necessary buildings. This was the subject of a letter to the Hon. J. H. Pope, the Minister of Agriculture, who replied that, while recognising the advan-

tage of such an institution, there was no vote from which the sum of money could be furnished. In the meantime a new Premier and a new Government have come into power, to whom application would have to be made to ratify the offers of the two former Premiers; and while awaiting the action of the Government Dr. Bessy thought the Society, by concerted action, might do much, whereby a suitable building might be erected, and thus have the grant of land secured at any rate. Dr. Bessey submitted to the Society a plan of such an establishment as he thought would be desirable, which would call for an outlay of about five thousand dollars, to build, equip, and put in running condition.

Discussion on Paper.—Dr. Hingston stated that to the efforts of Dr. Bessey was very much due the removing of the strong opposition on the part of the French, by using animal virus in vaccinations; he, however, took exception to the view of Dr. Bessey in regard to the transmission of syphilis by vaccine lymph, which was believed to be impossible by some of the ablest men in Europe; but, when such infection did occur, it was through the blood of the crust and not from the lymph.

Dr. Osier asked Dr. Bessey for definite figures as to the proportion of figures of children vaccinated direct from the heifer and those from humanized vaccine. In regard to the absolute immunity of pure lymph he took it that Dr. Hingston meant that the syphilis is conveyed in the formed matter of the blood, and, if conveyed in the red blood corpuscles, why can it not be also carried in the white cells? Now it is a fact that you cannot get lymph without colourless corpuscles; if you take it ever so pure and clear it will contain a few colourless cells, and as it gets older these multiply by taking nourishment from the lymph.

Dr. F. W. Campbell said that the Local Government should be conferred with to have an Order-in-council passed donating the land, and then the Dominion Government should be asked for a grant towards putting up the buildings. He thought it very important that a large stock of animal virus should be always obtainable, and he thought the Society should act with Dr. Bessey in this matter.

In reply, Dr. Bessey said in the absence of positive records, he should judge that 50 per cent. of the cases were vaccinated from the heifer lymph, and the remainder with early removes from healthy children. In reply to Dr. Hingston, he held that the serosity of vaccine was quite capable of being the medium for conveying the syphilitic germs, as readily as a pus granule or blood corpuscle; it was as much a secretion of the body as was the saliva, the perspiration, or the seminal fluid, either of which, as has been frequently demonstrated, are capable of transmitting the syphilitic poison.

It was then moved by Dr. Hingston, and seconded by Dr. Campbell, and resolved: "That this Society desires to express its deep appreciation of the necessity that exists for a sufficient supply of reliable bovine vaccine lymph, and expresses its confidence in the purity of the supply afforded by Dr. Bessey during the past few years, and will hail with satisfaction any assistance the Local and General Governments may be pleased to afford in order to secure an efficient supply for the Dominion of Canada."

The matter was then referred to the Council to take action.

Dr. Hingston laid before the Society several "proofs" of a pamphlet now being printed for him, as a note-book on ovarian and other abdominal tumors. He said that those of Spencer Wells and Hodges were more than complete in the matter of history, but incomplete in what related to diagnosis. While many diseases with which ovarian tumors might be confounded were to be found in the pamphlets of those writers, much had been omitted, and to supply these omissions was the purpose of the pamphlet. Dr. Hingston stated he had followed the arrangement by Hodges, and restored much of what had been omitted from Wells, and had supplemented, chiefly under the head of diagnosis, what was not to be found in the note-books of either.

CANADA

Medical and Surgical Journal.

MONTREAL, DEC., 1882.

VITAL STATISTICS.

It has long been apparent that the Dominion Government are really anxious to provide for some systematic supervision of the public health, and will not remain content simply with words and promises. The medical profession have been for many years taking a deep interest in the progress of movements tending in this direction, and have repeatedly, through the Canada Medical Association and their own journals, called upon our legislators for a comprehensive scheme by which to regulate sanitary matters throughout the country. One of the very first steps necessary is to establish some uniform method for the collection of vital statistics. As our readers are aware, a small sum was appropriated at the last session of Parliament for this purpose. This practical move has set on foot a good deal of discussion in all our towns and cities. Hon. Mr. Pope, who has throughout exhibited great earnestness in this matter, arranged for a representative delegation from the various Health Boards and from the medical profession to meet himself and some of his colleagues at Ottawa and have a general discussion and interchange of views. This interesting and important event took place in that city on the 7th inst. The following delegates were present:—

Montreal—Col. A. A. Stevenson, Ald. J. H. Mooney, Mr. F. N. Boxer, J. A. U. Beaunry, C.E., Ald. Fairbairn, Drs. Hingston, Howard, Larocque, Campbell and Mount. Quebec—Mayor F. Langelier, Drs. Roy, R. F. Rinfret, N. E. Dionne. Toronto—Drs. Oldright, Canniff, G. Wright and Playter. Ottawa—Dr. P. St. Jean, Mayor; Drs. J. A. Grant, John Sweetland, S. Wright, H. Wright, H. Hill, H. B. Small, F. X. Valade, A. Robillard

(Health Officer), R. Mark and A. J. Horsey. Halifax—Drs. Wickwire, Moren, Almon, Farrell, W. H. Maloy, M.P.P., and Mayor Fraser. Charlottetown—Dr. Conroy. St. John, N.B.—Drs. Botsford, Harding, Daniel and Bayard. Fergus—Dr. G. Orton, M.P. Londonderry—Dr. Macdonald.

The delegates were received by the Hon. Mr. Pope, Sir Chas. Tupper and the Hon. A. P. Caron. Hon. Mr. Pope explained the present state of things and the desirability of effecting a radical change. A general discussion ensued, when the following resolutions were passed, which sufficiently show the gist of the various speakers' remarks :—

Resolved,—That, in the opinion of the meeting, in order the better to prevent disease and preserve human life, it is advisable that the Dominion Government should organize and sustain a uniform system of vital statistics for the Dominion.

Resolved,—That, as immediate action is necessary, the Federal Government be invited to initiate at once a system of vital statistics where organized Local Boards of Health are established, so that the statistical information may be utilized by these bodies.

Resolved,—That, as Provincial legislative action is necessary, it is suggested to the Federal Government that it communicate with and secure the co-operation of the Provincial Government to pass such legislation as will harmonize with and obtain the object of the preceding resolutions.

Resolved,—That it is desirable that a central bureau of statistics be established, and if found to be within the province of the Federal Government, a comprehensive system of health returns.

Resolved,—That inasmuch as it appears by the British North America Act that matters of public health are delegated to the Local Government, this delegation has not included it with the subject of vital statistics; nevertheless, they are of opinion that it would have been better had it been under the direction of the Federal Government, and beg to suggest that an effort be made to obtain an amendment to the constitution in that direction.

Sir Charles Tupper urged that a united effort should be made to obtain power for the Federal Government to take charge of a General Sanitary Bureau. As these matters are now placed under the Local Governments and the municipal authorities by the British North American Act, it will be necessary for them separately to petition for permission to resign their functions to the central authority. If, then, the latter represent to the Imperial Government, their willingness to assume control of the Sanitary Departments, it is most probable that an amendment to that effect to the Confederation Act could be obtained.

The suggestion of Sir Charles Tupper is well deserving of

attention, and we hope that before long it may have secured the desired result. On the whole, the deputation was a most successful one, and we congratulate its members upon having, in some cases at considerable sacrifice of time, thus aided in furthering a work which may yet prove of inestimable benefit to the whole country.

CHRYSOPHANIC ACID IN THE TREATMENT OF PSORIASIS.

Any one who has had experience in the treatment of this disease by the old-fashioned method with tar ointment, and who employs chrysophanic acid for the first time, cannot fail to be struck with the almost marvellous effect of this drug. Yet there are many in the profession who do not know its value, and there are a few who doubt its efficacy. At a recent meeting of the New York Dermatological Society, this was made the subject of a very interesting discussion, and certain conclusions were then formulated and pretty generally agreed upon, which we consider of sufficient value to present to our readers:—

1. That chrysophanic acid is perhaps the most efficient agent known to the profession for the external treatment of certain cases of psoriasis, especially chronic cases which have resisted other methods of treatment.

2. That its range of application is limited; in children, in patients with sensitive, irritable skins, and acute cases, generally, it is contra-indicated.

3. That in psoriasis affecting the face and hairy scalp, the intensely irritating action producing puffiness of the face and eyelids, and its discoloring effect upon the hair render its employment impossible.

4. That it is prompt in its action, a week or ten days' active treatment being usually required to develop its full therapeutic efficacy.

5. That its curative effect is only temporary; it does not afford a safeguard against relapses.

6. That it probably acts only locally and by virtue of its irritating properties, setting up a substitute inflammation, which modifies or corrects the tendency to overgrowth of epidermic cells.

7. That its employment is attended with certain objectionable results, some of which always follow its use, while others seem to depend upon idiosyncrasy, physiological and morbid predispositions, etc.

8. That a brownish, prune-juice discoloration of the skin which persists long after the application is discontinued, a reddish staining of the hair and nails, and an indelible dyeing of the clothing are inseparable from its use.

9. That the erythematous and furuncular inflammations which occasionally follow its use may be classed as incidental effects, as they do not always depend upon an excessive strength of the preparation employed, but are frequently manifest after a mild application; intense dermatitis,

resulting in exfoliation of the epidermis in large flakes, has been observed after an application of 10 grs. to the ounce.

10. That the strength of the ointment recommended by Balmanno Squire (3ii to 3i) is excessive; a milder strength (20 grs.-3i to 3i) being usually sufficient to develop the full therapeutical virtues of the drug.

11. That in other diseases for which it has been recommended, as acne, favus, pityriasis versicolor, eczema marginatum, etc., chrysophanic acid possesses no advantages over certain other drugs which are commonly used.

Pyrogallic acid was thought to be the best substitute for the other in cases where the skin was unusually sensitive, or where the disease attacked the scalp and face. With regard to the strength of the ointment of chrysophanic acid, in our own experience we have never found it necessary in any case to employ a stronger application than one containing 10 grains to the ounce. In one case, which we are in the habit of citing, a strong man was made alarmingly ill by the application of an ointment of the above strength. The case was one of general diffuse psoriasis, and on the second day of the treatment he was seized with a rigor, his temperature rising to 105°, and the body was found soon after to be covered with a rash identical in many of its characters with that of scarlet fever. This peculiar action of the drug was not understood at the time, so that some uneasiness was felt for the moment. The feverish symptoms of course rapidly subsided, and a complete cure of the psoriasis followed. Ever since, we have preferred, especially in private practice, to feel our way, by commencing the treatment with an ointment not stronger than six grains to the ounce. One of the greatest objections raised against chrysophanic acid is its unfortunate property of staining the clothing. This can be obviated in great measure by employing a species of varnish recommended by Dr. Fox of New York. This is made by suspending about 10 per cent. of the acid in flexible collodion. By rubbing up the powder first with a little alcohol and ether, and then adding the collodion and shaking, a more uniform mixture is made. Dr. Fox thinks that the varnish is not quite so efficacious as the ointment, but, after drying for ten minutes, will not stain the clothing.

CAUSES OF CONSUMPTION.

Last year Dr. Playter of Toronto addressed a circular to a large number of medical men in Canada and the United States,

containing a series of questions relative to the personal condition and hygienic surroundings of phthisical patients. He has now published a small pamphlet which embodies and tabulates the answers received from his correspondents with reference to 250 cases of well-marked tubercular pulmonary consumption. The results arrived at, as might have been anticipated, confirm many of the well-known facts concerning the etiology of pulmonary tuberculosis. A few points, not so generally recognized, are emphasized by Dr. Playter in his general conclusions. "One of the most marked features, and perhaps the most important one, brought out in the analysis of the cases, is the evidence that those who die of the disease under consideration have a small pulmonary capacity—a small, contracted chest. This is shown not only in the average of the cases, but in every case—in not one did the circumference of the chest even approximate that of a well-developed individual of the same height and weight." Another point, specially interesting now with reference to the germ-origin of tubercle, is that of the contagiousness of phthisis. A considerable proportion of the reported cases, 28 per cent., had been known to be much and directly exposed to the disease, nursing and sleeping with friends suffering from it. The writer seems to accept the existence of the bacilli as the cause of the disease, and thus expresses the reason why contagion is not more frequently witnessed. "The bacilli of consumption in the human organism must meet with favorable soil and favorable conditions in which to propagate before they can give rise to the fatal malady. These conditions are secondarily through inharmonious and defective constitutional organization and want of vigor, coupled with, very likely, accumulations in the body of detritive matters, and, primarily, from want of capacity for the perfect performance of the respiratory function—from too small lungs." The practical inference from this is "to increase, in early life, by judicious physical exercise, the size and capacity of the respiratory organs."

CEASED TO EXIST.

We regret to have to announce that, with the issue and completion of its eighth volume, our esteemed contemporary, the

Archives of Dermatology, ceases to exist. The reasons given for cessation of publication are pressure of other work on the part of its talented editor, Dr. Bulkley, and the fact that a monthly journal devoted to the same specialty has recently appeared in New York. We shall miss the *Archives* from our table, having long regarded it as one of the most ably-conducted of our exchanges. The department of clinical reports and illustrations, conducted by the editor himself, has always been replete with practical suggestions, and must have been a great boon to the busy practitioner, whose time for reading is often so limited. While Dr. Bulkley has laid down the editorial pen, we trust he may be induced, from time to time, to give the profession the benefit of his vast experience, in the shape of a contribution to the literature of diseases of the skin.

KINGSTON MEDICAL SCHOOL.—We regret to see that trouble has arisen at the Royal College of Physicians and Surgeons of Kingston between the male and female students. Dr. Fenwick, in his physiology lecture, made some remark which was loudly applauded by the male students, but at which the ladies took offence and left the room. A meeting was then held by the students, and a memorial sent to the Faculty asking that the ladies should be excluded, and stating that if the request was not complied with the class would leave for some other school. The Faculty refuses to be dictated to, and so far a settlement of the difficulty has not been reached. Only about seven of the students have paid their class fees, so that the majority are in an awkward position, and cannot get their half session certified until all dues are settled with the school. We understand that an application for admission to McGill College was refused unless the half session was certified by the authorities and the students left "in good standing." We trust that an amicable settlement will soon be reached, and that this temporary difficulty will not interfere with the continued prosperity of the Kingston school.

THE TORONTO SCHOOLS.—A discussion has been taking place on the advantages of a union of the Toronto and Trinity Schools, and the *Mail* has interviewed many of the leading Toronto medi-

cal men on the subject. It is not at all probable that a fusion will be effected. Some advocate a Hospital School. Where is the Faculty of Medicine of Toronto University?

MCGILL MEDICAL SOCIETY.—We are glad to hear of the flourishing condition of this useful organization, now in its seventh year. The state of the student's society at a medical school is a good index to the education and intelligence of the class of men in attendance. We do not hesitate to say that among the very best features of the Edinburgh and London Schools are the societies where the students meet and discuss various subjects. Constant attendance at a society is a valuable adjunct in the *education of a student*. A number of new books have been added to the library, and we notice that the materia medica cabinet is being utilized by the primary men.

BALFOUR MEMORIAL.—The friends of the late Prof. Balfour, to whose untimely death we referred in the August number, have decided to establish a fund for the promotion of biological research, to be known as the Balfour Fund. A large sum has been already subscribed. In the last number of the *Archiv für Mikroskopische Anatomie*, Prof. Waldezer of Strasburg pays a splendid tribute to the work and worth of this young investigator.

NURSES.—We are glad to observe that a systematic arrangement for the registration of nurses has been provided for in Toronto. This matter has been several times spoken of for the city of Montreal, but nothing has yet been done. It is a most desirable thing, and, when well managed, proves of great service both to the profession and the public. We should be glad to see a move made in this direction.

ANNUAL DINNER OF THE UNDERGRADUATES IN MEDICINE, MCGILL UNIVERSITY.—This reunion will take place at the Windsor Hotel, on the 18th inst. An energetic committee are making all the necessary arrangements, and a very pleasant meeting is anticipated. We hope to see a large number of old city graduates amongst the subscribers.

—At a meeting of the senate of Toronto University, on the 8th inst., it was decided to establish nine Fellowships, tenable

for three years, with salaries of \$500 per annum. No more important step in the interest of higher education has ever been taken by a Canadian University. At the same meeting, the enactment was cancelled which requires candidates for the M.D. degree to write the thesis in the Convocation Hall.

—A notorious character named Jean Jacques, *alias* Johnny Leblond, has recently been discharged from the common jail at Three Rivers after having served a term of three months' imprisonment. He was prosecuted by the Provincial Board for the illegal practice of medicine and fined \$25; being unable to pay, he went to prison. He hailed from the Parish of St. Pierre les Becquets, Co. Nicolet, and it speaks well for the district that Johnny's coffers were so scantily filled. We also learn that an action has been entered in the name of the Board against Dr. James D. Stewart, of Belleville, Ont., for having practised medicine in the Province of Quebec without having taken out the license.

—We have received the Annual Report of the Surgeon-General of the United States Army for 1882. The Report is based upon an average mean strength of 20,778 white, 2,265 colored troops, and 245 Indian scouts. It contains some interesting statistical matter concerning the mortality in the army, both from disease and from wounds and accidents. The medical library of the Department at Washington now numbers 57,000 volumes and 63,700 pamphlets. By means of the enormously expensive catalogue now in course of preparation, this great mass of literature is being made available to the whole profession of the country.

Obituary.

DR. DICKSON OF KINGSTON.—The presiding officer of the Kingston School of Medicine has also been called away, and it becomes our mournful duty to extend our sympathy to that Faculty at the loss which it has sustained. Dr. Dickson was born in Ireland in 1819, and received part of his medical education in Belfast and Glasgow. In 1837 he came to Canada, and for several years was with Dr. Hutchinson of Peterborough. In

1842 he took the license of the Provincial Board, and also graduated at the University of New York. In the same year he settled in Kingston, and for forty years occupied an honorable and prominent position in the community. In 1854 the Medical Faculty of Queen's College was organized, and Dr. Dickson became the President and Professor of Surgery. In 1863 he took the membership diploma of the London Colleges, and in 1867 the Fellowship of Royal College of Surgeons of Edinburgh. In 1866, when the Medical Faculty of Queen's became a separate corporation under the title of the Royal College of Physicians and Surgeons, Dr. Dickson was chiefly instrumental in obtaining the charter and in reorganizing the school. He had the honor of being the first President of the Ontario Medical Council, 1866. For ten years he was surgeon to the Penitentiary, and from 1869 to 1878 Medical Superintendent of the Rockwood Asylum. Dr. Dickson had an extensive reputation as a surgeon, and his zeal and abilities materially assisted in establishing the reputation of the Kingston School of Medicine. For several years he has been prostrated with paralysis, and had relinquished all professional duties, though retaining full possession of his faculties.

DR. RUSSELL, SEN., QUEBEC.—The old capital has lost one of its leading medical men by the death of Dr. Russell on the 7th inst. The deceased was a native of Quebec, son of the late Capt. Russell, and member of a family with strong medical predilections. Two brothers, Frank and John P., also studied medicine; the latter is one of the leading practitioners of Toronto. The subject of this sketch began his career as a student of Dr. James Douglass of Quebec, and then proceeded to Edinburgh, where he graduated with honors in 1843, taking obstetrical and anatomical prizes. Returning to Canada, he settled in his native town, where for over 40 years he has enjoyed the confidence of the public in a high degree. In all matters relating to the welfare of his profession, Dr. Russell took a lively interest. He was for over 30 years a governor of the College of Physicians and Surgeons of Lower Canada, and held the presidential chair. He was one of the original members of the Dominion Medical Association, and entered actively into the work of the Society in

the early years of its existence. The Doctor had a keen, sharp intellect, was a good debater, and never seemed so happy as in the heat of controversy. He was not a frequent contributor to the journals. His son has been in practice in Quebec for eight or ten years, and is a worthy representative of the family.

PROFESSOR DRAPER.—By the death of this distinguished man American science loses a bright ornament and the profession a member identified with its best interests. He was a son of the late Dr. J. W. Draper, the celebrated chemist and writer, and from his father received a thorough training in chemistry and medicine. He taught physiology for some years at the University School, was one of the staff of Bellevue Hospital, and a practising physician in New York city. Astronomy was his favorite study, and in this he made his scientific reputation. He was the most successful of celestial photographers, and had photographed the nebula of Orion and the spectra of more than 100 stars. The discovery with which his name will be chiefly associated is the presence of oxygen in the sun. He was a man of large private means, which were liberally spent in the cause of science.

DR. THAYER OF BURLINGTON.—The profession of Vermont and the medical faculty at Burlington have sustained a heavy loss by the death of this well known physician. Born in 1817, he studied with his father and graduated in 1838. From 1854 he practised at Burlington, where he occupied a prominent position as a teacher, while his reputation secured an extensive practice. His opinion was held in high esteem by many of his Canadian colleagues on the border. To his energy and zeal the profession of Vermont owe the re-establishment of the Medical School at Burlington, which was founded originally in 1823, closed in 1836, and reorganized by him in 1854. After many struggles and difficulties, he had the satisfaction of seeing it placed on a solid foundation and the class list swell from 20 or 30 to near 200. During the war he organized the medical service of the State, and was appointed Surgeon-General. He was in active practice to the end.

PROFESSOR GULLIVER.—This well-known anatomist and physiologist died at Canterbury, England, on the 17th ult., in his 78th year. He was for some years Hunterian Professor at the College of Surgeons, and is best known in connection with investigations on the blood and lymph.

Personal.

H. E. Poole, M.D. (McGill, '80), has moved to Ormstown, P. Q.

H. E. Heyd, M.D. (McGill, '81), has gone to Buffalo, N. Y.

J. C. Shanks, M.D. (McGill, '81), is at Howick, Que.

Dr. T. Wesley Mills has returned from a short professional trip to Colorado.

W. C. Cousins, M.D. (McGill, '82), has passed the L.R.C.P. and L.R.C.S., Edin.

H. V. Ogden, B.A. (Trinity), M.D. (McGill, '82), has commenced practice in Milwaukee.

Fred. H. Mitchell, M.D. (McGill, '72), who is at present practising in Winnipeg, was in town for a few days.

Kenneth A. J. McKenzie, M.D. (McGill, '81), has left for Portland, Oregon, where he intends commencing practice.

We regret to learn that Dr. J. J. Woodward, of the U. S. Army Medical Museum, has not been benefited in health by his residence in Europe; no hopes are entertained of his recovery.

We are pleased to see that our friend and class-mate, Surgeon-Major Keefer of the Bengal Army, who has been serving with the Indian contingent in Egypt, has received the Order of Osmanieh for service during the war.

We have received the announcement of the University of Kansas City. Alex. Jamieson, B.A., M.D. (McGill, '77), is President of the Department of Pharmacy and Professor of Chemistry. The University is to be congratulated in having so competent a man at the head of such an important department.

In the recent elections for the Legislative Council of Prince Edward Island, Dr. Fraser was returned by a large majority for the first district of King's County. The Island physicians are

ardent politicians ; they have contested seven seats in the last Local and Dominion elections. We are sorry to learn that Drs. Robertson and Jenkins have both been unseated owing to some informality.

Medical Items.

—Mr. Geo. Critchett, the well-known London oculist, died on the 18th ult., aged 65, from cystitis and enlarged prostate. He is succeeded in the same specialty by his son, Mr. Anderson Critchett.

—Dr. Oliver Wendell Holmes has resigned the Chair of Anatomy in the Medical School of Harvard University, which he has held since 1847. The *Boston Medical & Surgical Journal* for November 2nd devotes its editorial to a sketch of his work during these thirty-five years.

—Mr. Oscar Clayton, F.R.C.S., has received the honor of knighthood in consideration of his services to the Prince of Wales. Some of the English medical papers consider this the result of Court favouritism only, and hold that many eminent names should have been thus distinguished before the one alluded to.

—The *New York Medical Journal* is to be published weekly, beginning with the New Year, instead of monthly, as hitherto. It will then have large, double-columned pages, affording space for certain new features, whilst its present *resumés* and other departments will be continued.

—The following would appear to be the very first Canadian record of a license to practise medicine in this country :—

“Le 2 Avril 1658, il est accordé une commission de Barbier-Chirurgien qui est plus tard solennellement enregistrée au Conseil Supérieur. C'est le premier diplôme accordé pour la pratique de la médecine en Canada.”

DOUTRE & LAREAU.

Droit Canadien, p. 41.

—Mr. Dujardin-Beaumetz, having had a long experience in the recent epidemic of typhoid in Paris, finds his success from an expectant plan of treatment equal to any of the so-called special methods. Baths give pneumonia. Quinine would be toxic if absorbed in full doses ; but it is not absorbed. Salicylic

acid produces no good effects. Carbolic acid is very dangerous. Charcoal is a simple disinfectant. He gives an occasional purgative, nourishment and support—and that is all.

ILLNESS OF SIR THOMAS WATSON.—This eminent physician has, we regret to learn, been prostrated by an attack of hemiplegia. He is now in his 91st year, and, up to the time of the seizure, had been in the enjoyment of excellent health. As we go to press, the news reaches us of the death of this Nestor of English physicians.

ROUGH ON RATS.—In a Toronto contemporary Dr. Zimmerman draws attention to the highly dangerous nature of the compound sold under this name. One fatal case of poisoning has already occurred. It has been found, on analysis, to consist of 99 per cent. of white arsenic. It is said to be “a convenient preparation by which anyone can obtain a powerful poison.”

DOCTORS *versus* PARSONS.—Professor Frotheringham, of the Medical Faculty Michigan University, has got into difficulty by making the sweeping assertion, during a lecture, that all parsons were liars. A Rev. Mr. Morgan, a student of the Faculty, instituted charges against the Professor, which were not sustained, and Dr. Frotheringham has been supported in certain counter charges which he made against his clerical student.

FLOATING KIDNEYS.—Mr. Lawson Tait does not believe in the existence of this condition. He says: “I put the floating kidney theory altogether on one side, because I have never seen such a thing, either in life or in a museum, nor have I met any one who has. In fact, I have no belief in its existence as a pathological incident.” An opinion widely at variance with that of a host of competent pathologists and clinicians.

—In a letter from a Colorado correspondent to an American contemporary, the writer propounds this question to the editor: “You will not object to my asking you whether you served in the cavalry branch of the service during the late unpleasantness?” and answers it himself, “I don’t believe you did, because you wrote the article upon *Equitation as a Preventive and Cure in Hemorrhoids*; not but the article has many good points—only cavalry men do have piles.”