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## CONTENTS.

ORIGINAL COMMUNICATIONS.	PROGRESS OF MEDICAL SCIENCE.	EDITORIALS.
Notes on the use of Ether in Obstetrics ..... 73	Clinical Lecture, 86. — Abstracts from a Practical Treatment on Diseases of Women.. 89	College of Physicians and Surgeons, 95.—Death of Dr. John Reddy, 96.—Making alleged fraudulent Doctors, 96.—New York Post Graduate Medical School, 96.—The Index Medicus, Personal..... 96
<b>SOCIETY PROCEEDINGS.</b>		
Medico - Chirurgical Society, Montreal ..... 76		

### *Original Communications.*

#### NOTES ON THE USE OF ETHER IN OBSTETRICS.

By CASEY ALBERT WOOD, C. M., M. D., Professor of Pathology, Medical Faculty, University of Bishops College, Physician to the Western Hospital.

(Read before the Medico-Chirurgical Society of Montreal, December 28th, 1883.

Until about a year ago it was my invariable rule to employ chloroform in midwifery, not only for the alleviation of pain during the first and second stages of labor but also for the performance of any of the operations incident to obstetrics. Since that time I have considered it advisable to modify my practice in some respects and to substitute ether, and in this paper I propose shortly to give my reasons therefor, and to ask of members of this Society, whose larger experience warrants their speaking with authority, their opinions upon the subject.

The only apology I have to offer for the assumption that it is possible to come to any conclusions of value in a small number of cases—twenty-six in all—is that attendance upon cases of midwifery

where it is necessary to employ anæsthetics, gives one ample opportunity to study their effects in each instance; for the moderately careful observer, who stays up half the night in the endeavor to relieve a parturient female, is likely to have sufficient chances of watching the progress of events and the extent to which they are influenced by the administration of remedies. In those cases where relief is called for in the first stage of labor, examples of which are most commonly found among primiparæ, where a slowly dilating or rigid os is represented by sharp pains, nervous excitability, inability to sleep, and, after a time by exhaustion, I have usually been able to succeed in quieting the patient and obtaining rest by giving her a full dose of chloral; or, if that fail, by administering a few doses of morphia. After a few hours of quiet, dilatation proceeds more quickly, and by the time the effects of the opiate have passed away the labor has progressed to the second stage. In the beginning of October, however, I had a patient who refused to exhibit this satisfactory phase of affairs. She was about to be confined of her second child; had been delivered of her first by the use of forceps after a prolonged labor, and was in great dread of a second ordeal. In addition to her nervousness the membranes ruptured after the os had dilated to the extent of a ten-cent piece, revealing an occipito-posterior presentation. The pains were not very severe or very frequent, but they appeared to exhaust the patient, who insisted upon my giving

her chloroform. I had a bottle of Squibbs' ether with me, and I proceeded to administer the anæsthetic in the usual intermittent way. I noticed, however, that the effect produced corresponded mainly to the *intervals* between the pains, and while it quieted her and gave her some sleep it did not "take the edge" off the pains as chloroform had previously done in my hands. As the affair progressed she seemed to gain courage and strength, rotation was accomplished, and the second stage was passed without the necessity of instrumental aid. As I walked home that night I felt that in that particular instance it would have served my purpose better to have given chloroform. A short time ago I attended a young woman, primipara, who had a long, tedious labor, and to whom I began the administration of ether when the head, presenting in the first position, had proceeded fairly into the second stage. She had been suffering from hemorrhoids for several days previously and was tired out before labor began. I gave her Squibbs' ether during and for a moment before the advent of each pain for over two hours. At the end of that time I endeavored, with the aid of the nurse, to apply forceps, but, owing to the difficulty with which she was brought under the influence of the anæsthetic I was obliged to send for my friend, Dr. Gaherty. With his aid she was safely delivered, and recovered rapidly and nicely from the ether and from the effects of the long labor. I questioned her closely, and she declared that she felt little or no pain from the time of my first administration of the anæsthetic until I determined to apply forceps. This case is a fair sample of my experience in ether administration during the second stage of labor. Where the pains are sufficiently severe, and the condition of the patient such as to warrant it, ether—good ether I mean—seems to me to furnish all the satisfactory results, both as regards its present and remote effects, that chloroform does, provided you give it slightly in anticipation of the pains.

I have had a number of cases of severe hemorrhage following the administration of chloroform given to produce complete anæsthesia while the forceps were used. So much so has this been the case, in my experience, that I have always looked out for at least a smart temporary post-partum bleeding, and usually found it. As far as I can judge from the small number of cases where ether was given I do not think such hemorrhage has been as frequent or as troublesome.

Last summer, however (and this is the only instance where I felt alarmed at the loss of blood

following the administration of ether) I applied the forceps to and safely delivered, with the help of the nurse and mother of the patient, a multipara of the lax-fibre variety, whose uterine fibres refused, during the whole labor, to respond to the stimulus of ergot and quinine.

In this case there was much anæmia, resulting from the large loss of blood following the relaxation of the uterus after a primary contraction which expelled the placenta. Two months ago I administered ether to a primipara, aged 41, nervous temperament, average-sized pelvis, first position of the head, after labor had lasted fourteen hours. There was early escape of the waters, and the head was obliged to dilate a rigid os. Opiates only partially relieved the condition, and when the os had dilated to the size of a half-dollar I gave ether in sufficient amounts to relieve the pain, and assisted the dilatation with my index and middle fingers. As soon as possible I increased the amount of ether, and when she was fairly under its influence I applied the long forceps and delivered. In spite of my endeavors to avoid injuring a very rigid perineum she suffered a laceration which extended quite to the margin of the anus. This I stitched up, and patient did well. In September last Dr. Gaherty assisted me in the application of forceps where a similar accident occurred. The patient was completely unconscious from ether for nearly an hour. She made a good recovery. With the assistance of Drs. Perrigo and Gaherty I applied Dubois' forceps, and delivered, of a still-born child, a woman with a contracted pelvis. Here the pains were intense early in the case, and continued so until the delivery of the child. I administered ether early, and she inhaled a fair quantity until the termination of the labor. In each of these three cases the patient said she had but a faint recollection of suffering pain after the anæsthetic was presented to her, and I have no recollection of any difficulty connected with the administration of the anæsthetic.

During the early part of the year, in a case of mine where I had the assistance of Dr. Kennedy, the labor of a primipara, aged 27; was obstructed by a cyst of the right broad ligament.

The presence of the tumor was early made out, and as the pains were violent from the beginning I gave ether in quantities necessary to relieve them. In this instance I have a distinct recollection of the action of the anæsthetic. I found that upon the early [pains, which lacked the bearing

down quality, and yet were severe, the ether did not act promptly or satisfactorily. To produce the required anodyne effects I was obliged to anticipate the onset of each pain, and to continue it during the whole period. That is to say, relief was obtained only by the use of almost as much ether as was required later on, when the tumor was punctured and the labor terminated by forceps. The patient made a good recovery. Without multiplying the record of these cases, valuable only as bearing on the question at issue, I would recount the relative merits, *meâ sententia*, of chloroform and ether in obstetrics something as following:

- (1) Owing to the agreeable odor, early effects, and perfect safety of chloroform as an anodyne agent, it is, without the least doubt in my mind, the agent best suited to alleviate the pain and calm the nervous irritability incident to the first stage of labor.
- (2) This statement is generally true of the expulsive period, where complete abolition of pain is not the object of the administration.
- (3) When, however, complete anæsthesia is required, as we find it necessary during the delivery of the child, and for the performance of operations following or preceding delivery, then it seems to me that chloroform largely loses its character as the obstetrical anæsthetic *par excellence*.

If it be acknowledged that considerations of safety must give way, in general practice, to greater conveniences of administration, etc., then, too, in the operations of midwifery, ether must supplant chloroform. If it can be shown that there is anything about the parturient woman which renders her less susceptible to danger during chloroform inhalation which does not equally apply to ether, then the force of this argument is much lessened. So far as I know this peculiar immunity does not exist. We know that it is in the practice of midwifery that the use of anæsthetics is considered least dangerous. By a process of natural selection, as it were, we then have women in the prime of life generally free from disease, with all their nutritive functions in good order—they naturally form the best class of patients to which *any* anæsthetic could be given—and this aside from the theories commonly put forward to explain such immunity from accident, such as increased cardiac development, the physiological cerebral congestion guarding against syncope, brought about by the effects of the uterus to expel its contents, and so on.

Other considerations may serve to modify these conclusions in the minds of practitioners, and the

first one is the inflammable nature of ether and its explosive quality when mixed with a certain percentage of atmospheric air. The kindling point of ethereal vapor and of its dilutions with oxygen is low, and when either of them comes in contact with flame an explosion is sure to follow. As the operations of the obstetrician occur frequently at night time this is a serious objection. The difficulty can be greatly overcome by a little care in preventing the near approach of flame to the inhaler or ether bottle, by thorough ventilation of the room, and by the exclusive use of covered lights. A common lamp is a very crude safety lamp, but it is a great improvement upon such naked flames as a gas jet, wax candle, or other unprotected light. I have never had an accident from an ether explosion. I think the danger could be nullified by the use of a modified Davy lamp.

In my experience vomiting is of as frequent occurrence after the use of ether in midwifery as of chloroform, and I do not think it occurs very often in either case. I think it will be generally admitted that, in view of the danger from post-partum hemorrhage, danger to the child and inherent danger to the mother, it would be more advisable to give ether, for its general anæsthetic effects for a long period, say an hour or longer, than to give chloroform for a corresponding period. Now it often happens that one is obliged to administer, in midwifery, an anæsthetic for a much longer time than was first anticipated, in which case it would be at least advisable to substitute ether for chloroform when a commencement had been made with the latter. I assisted, last May, the President of this Society to deliver a woman whose labor was complicated by a labial hæmatocele which had burst and caused considerable hemorrhage. In this instance I am sure that, remembering the length of time she was under ether, about an hour and a half, the ease with which she was kept under its influence, the confidence with which its administration was left for a large portion of the time to the nurse—all these made me feel that ether was the anæsthetic for that particular case. I have here to refer to the matter I have just spoken of—the confidence with which, in view of its greater safety, the administration of ether can be given over to the nurse or to anyone whom the exigencies of the case have left in possession of her faculties.

In country places this rule applies with greater force than it does to city practice; but it often happens that even in the city it is not convenient, desirable or necessary to call in a brother practitioner. In such cases, it seems to me that ether possesses considerable advantage over chloroform. Finally, in labors fatal to the mother, where an anæsthetic has been employed for any length of time—and I have as yet fortunately had no experience of such cases—it may be a relevant question to ask, would it not be a satisfaction to know that ether had been given and not chloroform?

## *Society Proceedings.*

### MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

*Stated Meeting, Nov. 23rd, 1883.*

T. A. ROGER, M.D., PRESIDENT, IN THE  
CHAIR.

*Uterine Fibroid.*—DR. GARDNER exhibited a number of fragments, making up a fibrous polypus he had removed from the uterus of a patient sent to him by Prof. Geo. Ross. The patient, age 48, unmarried, presented no evidence of ever having been pregnant, is very fat, and very anæmic. Gave a history of frequent hemorrhages and watery discharge for a few years, with little or no pelvic pain. On examination, the ostium vaginae was narrow and rigid; vagina distended to the extent of the pelvic cavity by a tumor of very firm, somewhat elastic, consistence, and uneven surface, about the size of a child's head. The tumor could be partially rotated. Diagnosis from inversion could not be made by the sound, as it could not be passed around the tumor. Under ether, the fundus uteri could be indistinctly outlined through the thick abdominal wall. After incision of the perineum and orifice of the vagina, a running noose of strong twine was slipped over the tumor and drawn tight around the pedicle. A vulsellum forceps was then fixed on the tumor, and successive portions removed, until at last a large portion—the residue of the growth—came away in the forceps. Very little blood was lost during the operation. The pedicle was found to be attached to the anterior wall of the uterus, above the internal os. It was trimmed off, and touched with Churchill's tincture of iodine.

The uterus measured three inches in depth. The vagina was tamponed with alum cotton with iodoform—not because of actual hemorrhage, but as a precautionary measure. The patient recovered without a bad symptom. There was no pain worth mentioning, and the temperature never rose about 99.5 °F. Microscopic sections made by Dr. Wilkins shewed it to be mainly fibrous in structure. In parts, smooth muscle fibres were to be seen.

DR. TRENHOLME said the diagnosis of a poly-poid tumor occupying the vagina is usually not very difficult to make out. The mobility of the tumor in this case, and the absence of vesical complication, together with the solid character of the growth, rendered it specially easy to diagnose. As to treatment, he (Dr. T.) had seen a case some time ago where the lady declined any operation, and in which he had simply twisted the tumor round a couple of times, and this cut off its blood supply. A short time afterwards the growth came away by sloughing, and the patient made a perfect recovery. In this case a similar mode of treatment would have been most likely followed with the same success without any operation whatever.

DR. GEO. ROSS said this case ought to be a warning against treating menorrhagia without making an examination. This patient was blanched and weak, and had been treated by several physicians, who never had made any examination of the pelvic organs.

DR. GARDNER also shewed the *uterus* of a woman aged 60, who died last August. The patient, referred by Dr. Roddick, was first seen at the University Dispensary for Woman on 30th January last. Unmarried; no signs of pregnancy. Menses ceased seven years ago. Health always good until a year ago. At the time she had a bloody discharge from the vagina, lasting a week; six months later a similar discharge, lasting three days; three months afterwards a recurrence of the discharge, which has continued to a slight extent ever since. It is pale, and free from clots. Intermittent hypogastric pain prevailed. On examination, abdomen flaccid, a few lineæ albicantes; cutaneous aspect of perineum slightly lacerated; vagina very narrow and atrophied, slight pale bloody discharge escaping. Bimanual examination reveals distinct enlargement and decided firmness of uterus; it is mobile. Cervix small, admitting with difficulty an Emmet's silver probe the size of an ordinary sur-

gical probe ; this entered four inches, causing free bleeding. The diagnosis then made was intra-uterine malignant growth. A month later patient returned for treatment. She was put to bed. The os was incised bilaterally, as no laminaria tent fine enough for introduction could be got. Successive tents were then introduced, until the finger could be inserted within the uterine cavity. A soft, easily broken down growth was at once detected. The sharp curette was used freely, and a large quantity of brain-like substance removed. Hemorrhage was free, but soon arrested by Churchill's solution of iodine and plugging. The result was undoubted, but temporary relief. After the pain and slight fever following the operation had subsided, symptoms returned, and in about two months later, after labor-like pains for a few days, a portion of the recurrent growth was found projecting through the now dilated orifice. The curette being again used, a much larger quantity of the same substance than at the first operation was removed. Decided, but temporary, relief again followed. After this she lived four months, suffering much from pain, fetid, but not bloody, discharge, diarrhoea, rigors, high fever and perspiration. Death took place from exhaustion. At the autopsy, made by Dr. Osler, the uterus is described as being enlarged eight times its normal size : it fluctuates, and is soft. Examined from the vaginal os, it presents a ragged, sloughy-looking mass projecting from the upper and left side. On section, the entire inner surface is involved in an extensive sarcomatous growth which has sloughed on the surface, and presents dark shreddy, soft disintegrating portions. The margin of the os is free, with the exception of one spot, at which the portion already noted projects. In places the growth is an inch thick. At one spot of the posterior wall the growth has perforated. Ovaries and broad ligaments unaffected. A secondary deposit was found on one pleura. During life, an elevated spot the size of a ten-cent piece existed on the anterior vaginal wall ; this had the same histological character as the growth in the uterus. Microscopic sections of the substance removed from the uterus during life showed the structure to be numerous small, round cells, with very scanty stroma.

DR. GARDNER said that in some quarters the treatment adopted might be considered as open to criticism. The most favorable cases for extirpation of the uterus were those of sarcoma. Freund's operation by abdominal section he considered ab-

solutely unjustifiable. If the uterus is ever to be extirpated, it should be done by the vagina, after Schroder's method. The great size of the uterus, and the narrow vagina, rendered the case unfavorable even for this method. He quite agreed with Dr. Reeves Jackson of Chicago in the views he put forth at the meeting in September of the American Gynecological Society in Philadelphia. Dr. Jackson believed that extirpation of the uterus, instead of saving life, had destroyed many years of life.

Dr. TRENHOLME remarked that if ever we were warranted in extirpation of the uterus, this was such a case. The uterus, though large, was free, and could readily have been brought down and removed. However, the fact of Dr. Osler finding secondary cancer deposits in the lungs shows that perhaps it was as well not to have attempted it. The smallness of the vagina, in his (Dr. T.'s) opinion, did not preclude the operation, if otherwise desirable. In cases of midwifery, cases are now and again reported where the whole vagina had been torn up to Douglass's fossa, and yet patients made good recoveries. Where necessary, we could divide the vagina and complete the operation.

Dr. OSLER exhibited a heart showing ulcerative endocarditis, and remarked that we have had exhibited at our Society the two kinds—one, quickly fatal, with typhoid symptoms ; the other more chronic. The case was diagnosed ulcerative endocarditis by Dr. Wilkins. The patient had also acute pneumonia. The heart shewed old sclerotic valves with deposit of lime salts. One of the chordæ tendineæ was ulcerated across. The cavities were dilated, and the left side hypertrophied. The spleen was also enlarged, and had numerous infarcts through it.

*Case of Puerperal Eclampsia.*—DR. A. L. SMITH read a paper on this case. He saw his patient about the seventh month, who complained of pains in her head, back and lower part of abdomen ; said she felt silly, and saw things upside down. Micturition painful and frequent, but urine scanty in amount, high colored, and loaded with albumen. Feet and eyelids swollen. A few hours later, was sent for, as she had taken a fit. Used a mixture of alcohol, chloroform and ether as an anæsthetic ; this arrested the clonic spasms, but unconsciousness remained, broken only by recurring seizures till evening, when a consultation with a senior *confrère* was sought, and twenty leeches

to the temples recommended. As the last leech fell off, consciousness returned, and she steadily regained her usual health. She was kept in bed on a strictly milk diet for several weeks, during which time the albumen decreased rapidly. Four weeks later Dr. Smith delivered her of dead foetus, much decomposed. She made a perfect recovery. Dr. Smith lays his success to the bleeding and rigorous milk diet, as recommended by Dr. Donkin, whom he quoted at some length.

Dr. GARDNER said that the efficacy of hypodermic injections of morphia or Liq. Battley was extraordinary in these cases. He had used it frequently with very satisfactory results, even where convulsions came on weeks before labor.

Dr. ROSS said the question of bleeding was divided. His own experience went against it. Only once saw good results follow, and that time the patient was a small, weak woman. He had several times seen strong plethoric women bled without any benefit. Has found chloral, given early, very useful, but morphia more reliable, and recommended hot air baths.

Dr. TRENHOLME said the pulse was a good indicator to bleed or not. If strong and bounding in a full-blooded person, believed bleeding to be the best treatment. convulsions came on some time before full time, then an opiate would be good. If at full time and os dilatible, give chloroform and deliver. He agreed with Dr. Smith's treatment of his case as regards the form of bleeding and milk diet.

Dr. GARDNER spoke highly of hot air baths in these cases.

Dr. RODGER said he had treated a good many cases of puerperal convulsions. Used to bleed if the person was strong, but of late, in all cases, uses hypodermics of morphia. Chloroform or ether have not given satisfaction, nor has he seen the good effects from chloral and bromide of potassium which others speak of. Some time ago had a patient six months pregnant, with 75 per cent. of albumen in her urine, who had a convulsion. He gave her a hypodermic of half a grain of morphia, repeating it in six hours. She had no more seizures till three weeks after. Again he used the morphia which stopped them for two weeks more, when pains came on, and she was delivered of a dead foetus.

*Stated Meeting, Dec. 14th, 1883.*

DR. RODGER, PRESIDENT, in the chair.

*Syphilitic Caries of inner table of skull.—Great thickening of Calvaria—Compression and Deformity of Brain.*—DR. OSLER exhibited the skull-cap and brain. The patient, a woman aged 35, had been in hospital many times during last six years with various symptoms of constitutional syphilis. Was not under regular constitutional treatment in the intervals. At one time had necrosis of right tibia. In November, 1882, was admitted with a small open sore in right parietal bone through which dead bone could be felt, and a probe passed far in between the bare bone and dura-mater, towards the vertex. Symptoms chiefly debility and severe right unilateral headaches. Was in hospital several times within last year, and amyloid disease of kidney was made out. During her last illness, as on the previous occasions, her intellect was clear, and although within a few days of her death she was dull and very irritable, it was probably due to the severe pains in her head and her increasing weakness. Never had any signs of local brain disease. The headaches were very severe at night. The external surface of the skull-cap was smooth, and on the right side, close to the coronal suture, was a small sinus through which a Bowman's probe could be passed. On removing the calvaria, which was moderately thickened in the supraorbital regions, a quantity of thick pus escaped. The dura-mater was thickened and strongly adherent posteriorly. The internal surface was smooth and did not present any adhesions. As shewn in the specimen, the disease is confined to the contiguous surfaces of skull and dura over the frontal and part of the parietal regions. The inner aspect of the bone in these parts is rough and carious, having an eroded, worm-eaten appearance, and covered with granulations; and towards the parietal bone, firm, solid fibrous masses unite it to the dura. The upper half of the frontal and the greater part of the parietal bones are thickened, measuring from two to three centimetres, and are exceedingly dense. The outer surface of the dura-mater shews numerous soft granulations springing from solid fibrous tissue. The falx in its anterior half is thickened, and the longitudinal sinus is in this part obliterated. The brain shewed no trace of coarse disease; the arachnoid was a little opaque, but the pia-mater was normal. The hemispheres were curiously deformed from the pressure to

which they had been subjected by the thickened bone and dura, and the pus between them. They are wedge-shaped, the base is at the occipital bones, where the greatest vertical height is eight centimetres, and the apex is at the orbital margin of the frontal lobes, where the height is only two-and-a-half centimetres. This curious deformity has been brought about slowly, and illustrates the degree of pressure to which the brain may be subjected, so long as it is applied gradually.

DR. HENRY HOWARD referred to the remarkable absence of cerebral symptoms in such extreme compression.

DR. OSLER also exhibited a skull from the museum of McGill College, with syphilitic destruction of the entire right parietal and part of the frontal bones, with caries also of the inner table.

*Epithelioma of Tongue—Excision—Erysipelas—Circumscribed Gangrene of Lung—Perforation of branch of Pulmonary Artery.*—DR. SHEPHERD

narrated the case and showed the specimen: THOS. W., aged 42, a strong, healthy man, came to the Montreal General Hospital in January, 1883, suffering from epithelioma of the tongue; this being near the tip, only a portion of the tongue (right half) was removed with the scissors by Dr. Fenwick. Two months ago he noticed that the growth was returning, and at the time of his re-admission into hospital, under Dr. Shepherd, early in November, it was increasing rapidly. He then had an epitheliomatous ulceration of the part of the tongue that remained, and also of the right tonsil and left anterior pillar of fauces; the floor of the mouth was infiltrated and hard. It was decided to remove the whole tongue. This was done on November 10th. Dr. Shepherd first ligatured the lingual artery of each side by a curved incision reaching from the front of the angle of the jaw to the hyoid bone, and up towards the symphysis. After ligaturing the linguals, the tongue was removed by scissors with very little trouble and no hemorrhage, after Mr. Whitehead's method. The right tonsil (or part of it) and the anterior pillar of fauces were removed also by scissors. After the operation the patient rallied well, and was fed for two days by nutrient enemata, the mouth being rinsed out frequently with a solution of Condy's fluid. For five days the man did well; there] was no fetor from the mouth, the wound] was granulating nicely, and the incisions made for tying the lingual were healing by first intention, when, on Nov. 15th

erysipelas appeared on the nose and rapidly spread over face, neck and head. Temperature rose to 103°-104°, and pulse became rapid (120) and weak. The erysipelas then spread over the chest, and the mouth now became sloughy; fetid breath was first noticed on Nov. 27th, at which time a slight cough developed, and some bronchitis, which was looked upon as septic. No rigors or sweatings had occurred. From this time patient became gradually weaker and weaker, in spite of the stimulating treatment, and died suddenly on December 2nd from hemorrhage. Dr. Shepherd remarked that at the time of the operation several cases of erysipelas had been admitted into the hospital from outside. With regard to the operation, he felt perfectly satisfied with it, the previous ligaturing of the linguals greatly facilitating the removal of the tongue by scissors, as all fear of hemorrhage was removed, and the scissors left a clean, instead of a bruised, surface, as is seen after the use of the écraseur. The method of operating had nothing whatever to do with the fatal result.

At the autopsy the wound looked in process of healing, and the cancerous masses had been removed. The linguals presented thrombi at the site of ligature. There was a small pocket of pus beneath the left sterno-mastoid. The trachea and bronchi were filled with blood. The right lung presented four areas of circumscribed gangrene, the left two, each about the size of small apples. Placing the lung under water and blowing water through the pulmonary artery, bubbles escaped from one of the gangrenous regions close to the root of the lung. Dissection proved, as the specimen shows, that the hemorrhage came from a small branch of one of the main divisions of the artery, which had been opened in the necrotic process.

DR. R. P. HOWARD spoke of the frequency with which gangrene of the lungs followed operations on the tongue and neck.

DR. GEO. ROSS mentioned having had a case of cancer of the œsophagus in hospital last winter which proved fatal from gangrene of the lung.

*Sarcoma of Lumbar Glands; Perforation of the Colon; Persistent Hemorrhage.*—DR. SHEPHERD presented the specimen, and gave the following notes: Man, aged forty-five, large, strongly built, weighing over two hundred and fifty pounds; sent for him on July 23rd, and stated that he had

beer, seized in the night with severe pain in the back and abdomen. The temperature was  $103^{\circ}$ , pulse, 120; tongue coated; great tenderness of abdomen, with fulness in left iliac region; no vomiting; bowels had been opened several times during the night. In the evening he was worse. Temperature,  $104^{\circ}$ ; pulse, 120; great abdominal distension with tenderness. On the 25th the temperature was normal, but the abdominal symptoms persisted, and there was diarrhoea and frequent vomiting. On the 29th he had a severe rigor, with temperature of  $104^{\circ}$ , and profuse sweating; tympanites and pain, with evidence of peritonitis. In a day or two he had another rigor, with severe vomiting and diarrhoea, and great abdominal distention. Dr. Ross saw the patient in consultation, and the conclusion arrived at was, that there was local suppuration deep in the iliac region. His condition at this time was very bad; pulse weak; vomiting incessant. With champagne and careful feeding the vomiting was checked, and he began to improve slowly, until in the early part of September he was able to move about the room. There was still fulness on deep pressure in the iliac fossa, but the thick layer of fat prevented a satisfactory examination.

About September 10th he began to pass a small quantity of blood—bright red—with the stools, and this increased until the daily amount was often as much as half a pint, and he became very anæmic. In the month of October he again took to bed; had severe rigors with high temperature and sweats, about every other day. At this time a tumor was made out in the hypogastric region, deep in the abdomen, fixed, solid, and not tender on pressure. Rectal examination negative. The loss of blood continued, and he got much weaker, and death took place on November 20th, after a profuse hemorrhage. The tumor had increased in size, and a week before death it seemed about the size of a child's head, and firmly fixed in the hypogastric region. The autopsy showed matting together of the coils of intestine with old peritoneal adhesions, particularly near the pelvis. The tumor was in front and a little to the left of the lumbar spine, and the sigmoid flexure was firmly united to it. The mass was readily turned out, and dissection revealed an extensive perforation of the bowel, as the specimen shows, and exposure of soft sloughing masses of the tumor. The wall of the colon was defective in an area two and a

half by one and a half inches. The growth was a sarcoma of the retroperitoneal lymph glands. There were no secondary tumors, and nothing of note in the viscera. The persistent hemorrhage for over two months had evidently come from the vessels of the exposed and sloughing part of the tumor. The repeated rigors were difficult of explanation; there evidently had been peritonitis, but whether local suppuration had occurred was not so clear, possibly it had in the progress of perforation of the bowel.

DR. GEO. ROSS remarked that he had seen the case several times, and it had offered considerable difficulty in the way of diagnosis. The amount of abdominal fat prevented a satisfactory examination, and the fulness in the iliac region was thought to be possibly a focus of suppuration. Later on, when the hemorrhage occurred, and a more evident tumor could be felt, the diagnosis was made of malignant growth, and from the situation and size, probably retroperitoneal and involving the bowel.

DR. R. P. HOWARD said that from the same symptoms he would have diagnosed as did Drs. Shephard and Ross. He congratulated them on having located the tumor so exactly.

*Small Tumor on Nerve: Intense Brachial Neuralgia; Removal.*—DR. SHEPHERD presented a microscopic section of a small tumor the size of a bean, which he had removed from a man's arm for painful neuralgia. The patient, a thin, nervous man, stoker by occupation, was admitted to hospital complaining of severe pain in the left arm—so bad that he could get but little rest at night. His appearance was that of a man suffering intensely. The pain was more severe at times, and was situated at the insertion of the deltoid, and from there ran down the back of the arm to the elbow. He also had numbness along the ulnar nerve. Just below the posterior fold of the axilla, internal to the brachial artery, a small nodule, the size of a bean, was felt, which on pressure caused agonizing pain. Dr. Bell admitted the case as one of neuroma. Dr. Shepherd had removed the growth, which was found connected with a small nerve, and closely united with the cellular tissue at the back of the artery. The man has had no pain since the removal, three days ago. The section of the tumor showed a fibrous capsule, and a small, angular-celled growth inside.

## TERTIARY SYPHILIS—CEREBRAL, LARYNGEAL AND RECTAL.

Dr. OSLER exhibited the specimens, and Dr. GEORGE ROSS read the following history :

L. R.—Æt 36, brought to hospital November 25th, 1883, in following condition: Almost complete paralysis of left arm, legs and right side of face, eyes fixed and staring, deviating to right; pupils moderately contracted; eyeballs prominent; no reflex on touching *left* cornea; both upper eyelids droop slightly, control over both bladder and rectum; tongue protruded to left side; when, with difficulty roused, answers questions rationally in whispered voice. (Sensation to pain, though dulled, is present in all extremities. No numbness or wasting of muscles.) Plantar reflex present in left leg, absent in right; can draw left leg up when asked to do so; offers very slight resistance to flexion and extension of left arm, but when raised and let fall it is quite lifeless; complains of pain in right occipital region of head. Temperature  $97\frac{1}{2}$  °F; pulse 50, regular; respiration regular, 16; urine contains no albumen, no casts; lungs and heart normal.

Patient has been under treatment for syphilitic affections of larynx, eyes and neurosis of palate and (super max bones). Had severe headache during whole summer.

History.—Went to bed in usual health on Friday night, 16th inst., four days before admission. Aroused her husband in the night, acted strangely and threw things at him.

On Saturday morning, 17th, acted rationally and had no complaints. Husband noticed she had something the matter with arm (left) in afternoon. On Sunday morning the paralysis was as complete as on admission; fell out of bed, and had to be lifted in.

(Lungs and heart normal; liver, dulness, normal).

Nov. 24th. Bowels not moved, given enema, quantity of matter (pus and stringy mucus) coming away. More inclined to sleep and breathing heavier; no reflex from right cornea to-day.

28th. Better; slight internal strabismus of right eye; speaks fairly well, considering that a hole, size of a quarter dollar, in roof of mouth.

Dec. 4th. Quantity of matter constantly coming from rectum for last few days. Digital examination shows a firm stricture, admitting barely index finger about one inch from sphincter, completely

around bowels. Has hard dry laryngeal cough. Reflex excitability now present in left eye, absent in right.

5th. Right eye much inflamed and a large corneal ulcer has formed.

6th. Patient more dull; considerable stridor in breathing. Examined by Dr. Major—Paralysis of adductors of right side and general stenosis as a result of it.

She gradually sank, and died on the 8th.

The brain presented extensive syphilitic disease at the base and in the right Sylvian fissure. The right temporo-sphenoidal lobe was firmly adherent in the middle fossa, and both dura and pia mater thickened and adherent. The fifth nerve, just as it entered the Gasserian ganglion, was involved in a mass of gummatous tissue, growing beneath, and attached to the margin of the tentorium. The nerve, for a quarter of an inch was swollen, and the fibres separated. The right optic nerve, close to the commissure, was surrounded by recent infiltration, and was inflamed and swollen to nearly double the size of the left nerve. The right sixth appeared involved, but the third was free. The right temporal and orbital convolutions were firmly united together by thickened and infiltrated tissue. The right middle cerebral was small, and a few lines from its origin passed directly into a gummatous mass which surrounded it for nearly half an inch. The membranes in the fissure beyond this were free, and the arteries small and full of white and red thrombi. The vessel in the gumma was quite occluded. The anterior cerebral artery contained a tolerably firm clot. The other vessels and the rest of the base looked normal. There was red softening of the convolution and parts supplied by the middle cerebral, particularly of the island and the ascending convolutions. Both nuclei of the corpus striatum were softened. The right optic disk was slightly swollen, but the intense neuritis evident near the commissure did not extend the whole length of the nerve.

There was extensive destruction of hard and soft parts of the palate, and ulceration of upper part of pharynx, and in the nose. The larynx presented advanced syphilitic disease: ulceration of both cords—most of the left. The greater part of the thyroid cartilage was neurotic, broken into three or four segments, and surrounded with sloughing tissue. There was suppuration beneath the sterno-thyroid and thyro-hyoid muscles.

The anterior part of cricoid cartilage was also necrosed. The rectum presented a large area of ulceration, and a short distance within the anus there was cicatricial tissue, in the form of an annular ring.

DR. HENRY HOWARD remarked on the frequency of cerebral syphilis, and gave his experience of its connection with acute mania and other forms of insanity.

**FIBRO-GLIOMA OF UPPER END OF ASCENDING FRONTAL GYRUS; JACKSONIAN EPILEPSY OF FOURTEEN YEARS' STANDING; THE LEG-CENTRE.**

DR. OSLER read a report of the case, and presented specimens and drawings in illustration.

The case occurred in the family of a medical man, and was remarkable from the length of time during which the convulsions had lasted, and the limitation of the lesions. After preliminary remarks on cortical epilepsy and the value of pathological cases in localizing the functions of the brain, the notes furnished by the Doctor were read, of which the following is an abstract: "Mary—, aged fifteen years and nine months. When sixteen months old fell on her head from the table and appeared to be much hurt, but recovered without any serious effects. Five months after, the left hand was noticed at times to be stiff and firmly closed. This continued to increase in severity and frequency for three months, when the leg became similarly affected, and two months later she was confined to bed, as the paroxysms had become general. For eight or ten weeks the seizure continued in this violent way; sometimes she had eight or ten in an hour. No loss of consciousness; then, after lasting for about seven months, they ceased, and she ran about apparently quite well.

She remained free from spasms for a year, when they returned and ran much the same course for six or seven months, and she then again recovered for about the same length of time. This went on until her eleventh year; months in which the spasms were severe and months in which she was quite free. One of the attacks is described by the Doctor as follows: "suppose her at the dinner table. She would suddenly say, 'Oh? I am going to have a spasm' (she knew this by the contraction of the left hand); she would then jump up and go to the sofa, get a cushion, lay it down on the floor, then lie down with her head on the pillow, and then jerk away in a spasm for half a minute or a minute;

laughing or talking all through it, and never losing consciousness. She would then get up, replace the cushion, and come back to the table and finish her dinner." About six years after the illness began, the left leg began to show signs of weakness, and gradually the foot turned in. During her eleventh, twelfth, thirteenth, and fourteenth years, the seizures were very bad, and she had no prolonged intervals. For six weeks, at one time, she lay unconscious, and had from fifty to eighty spasms in the twenty-four hours. As the attacks became less frequent she was able to sit up in bed or in an easy chair, and read or do fancy work. Last Christmas, when she was fifteen years of age, the spasms suddenly ceased, and she was ten months without one. A week before her death they returned with great violence, and increasing frequently until they became almost continuous, and for two days there was coma. Three hours before death they ceased, and she passed away quietly. The left arm and hand were weak, not wasted; the left foot was flexed inwards at right angles, and firmly fixed in that position. In reply to questions, the Doctor gave some additional particulars. The spasms always began in the left hand, and appeared to extend to the leg first, and then to the face. The intellect was clear, and she was though without special instruction, beyond her years in intelligence and general information. The clinical history may be briefly given as follows: Cortical epilepsy for fourteen years; remarkable intermission of from six to twelve months. Spasms began in the left hand, at first mono-brachial, then extended to the leg, afterwards became unilateral, and finally general. No loss of consciousness for some years. Weakness of left arm, permanent contracture of right leg and foot. Intellect unaffected.

The brain was large and well formed, dura-mater natural, no adhesions or spots of thickening on the pia-matter, vessels much congested, hemispheres symmetrical, no wasting of convolutions of puckering. In slicing the organ *pre-frontal* and *pediculo-frontal* sections normal. A section three centimetres in front of the fissure of Rolando showed nothing abnormal. In making the *frontal* section, the knife passed through a hard resistant mass in the right hemisphere, occupying the upper end of the ascending frontal convolution. The knife passed exactly two centimetres in front of the fissure of Rolando, and the mass occupied the superior fasciculus of the white fibres, nowhere reach

ing the surface and scarcely touching the gray matter. In this exposure it measured fourteen millimetres in width by sixteen in vertical extent, and was eight millimetres from the surface of the paracentral lobule, ten millimetres from the top of the gyrus close to the longitudinal fissure, and fifteen millimetres from the external surface of the convolution. In a section seven or eight millimetres behind the *frontal* the mass was visible as a small round puckered portion just at the edge of the gray matter, at the bottom of a small sulcus passing into the ascending frontal gyrus from the fissure of Rolando. The mass occupied the upper end of the convolution, and had an antero-posterior extent of about seventeen millimetres, and a vertical of fifteen or sixteen millimetres. It was almost entirely within the white matter, but touched upon the gray at several spots. It had a fibrous appearance with ill-defined borders; and vessels could be seen in it. The *parietal* and other sections were normal. The right crus was badly torn, and no sclerosis could be seen, but the right half of the medulla was smaller than the left, and presented evidence of descending degeneration. The cord was not examined.

Histologically the mass appears to be a fibro, glioma. The delicate fibre elements are in excess but there are many large cells with prolonged fibrillar process. The blood vessels are numerous. So far as examined, the cells of the gray matter in much the immediate vicinity did not appear to be altered.

Dr. OSLER remarked that lesions causing cortical epilepsy were rare in the white matter, but this one was close enough to the gray cortex to induce the irritative effects and the excessive motor discharges causing the convulsions. Gliomata were slow-growing local tumors, and instances were on record of nearly as long duration as in the case under consideration. Dr. Jackson had described one of ten and another of twelve years' standing. The remarkable intermissions were strange features in these cases; periods of quiescence alternating with periods of excessive irritation. The situation of these lesions was of interest in connection with the crural monoplegia and contraction. The tumor occupied largely the anterior portion of the paracentral lobule, the region which has been found affected in the few recorded instances of paralysis of one lower extremity of cerebral origin. The leg-centre is placed in this lobule by Ferrier and Charcot, and this

case is in confirmation, as we may reasonably conclude that the lesion, by interfering with conduction from this centre, induced the paralysis and subsequent contracture.

Dr. HENRY HOWARD said: This was, perhaps, one of the most interesting cases that ever came before this Association, because the pathology of the case fully explained all the phenomena exhibited, while the patient was living. We perceive that there was motor convulsions, but no loss of consciousness. The diagram before us shows the reason why the disease was confined to the higher motor centres; the sensory centres been free. With the exception of motory convulsions the patient had otherwise enjoyed good health; muscles and cellular tissue well developed. The reason is obvious. The motor nerves that suffered are not the nerves of nutrition. Nutrition depends upon the sensory nerves, and their centres, in this case, were normal. If all pathological investigations showed us cause for effect like the case under consideration it would be a great satisfaction to the physiologist.

Dr. HAMMETT HILL, of Ottawa, narrated the case of a lumberman who was struck on the head with a pike, and received a depressed fracture. He had severe seizures, and was trephined with success, and he had no fits for eighteen years, after which they recurred at long intervals, possibly due to bony thickening about the seat of trephining.

*Early Symptoms of Tabes dorsalis.*—Dr. STEWART exhibited a man, aged 33, clerk, whose only complaint was of dimness of vision. He first noticed failure of his sight ten weeks ago. Three weeks after he consulted Dr. Buller, who diagnosed the case as one of *Tabes dorsalis*. Twelve years ago he saw double for a week. In the year 1879 he recollects seeing double for about three days. With the exception of these two occasions, and a few days during which he was sick from measles, he has always enjoyed excellent health. He never had syphilis. The family history is unimportant. Three years ago he worked for several months in a very damp cellar.

*Present state:*—There is permanent contraction of the right pupil (myosis). There is loss of reflex contraction of the pupil (Argyll Robertson symptom). Both pupils readily contract on accommodation. In addition to the loss of reflex contraction, he has also undoubted loss of reflex dilatation of the pupils. There is well marked

atrophy of both discs. The patellar reflex is absent in both legs. This is the only symptom characteristic of *Tabes dorsalis* present, with the exception of the eye symptoms. There are no lightning pains, no paresis of the bladder or rectum, no ataxia, no delayed, lost or perverted sensations. The skin reflexes are present. Notwithstanding the absence of some of the prominent symptoms, there can be no doubt whatever about the nature of the case. It is an undoubted case of *Tabes dorsalis* in its pre-ataxic stage. The case is a good example of what is now generally conceded, viz., that *Tabes dorsalis* is essentially a disease of the sensory tracts. Three of the most prominent symptoms are failure of the normal reflexes. There is (1) loss of the reflex contraction of the pupils; (2) loss of reflex dilatation of the pupils; (3) loss of the patellar reflexes.

*Treatment.*—During the last seven weeks the patient has been treated with the *faradic brush* three times weekly, after the manner recommended by Rumpf of Bonn.

In reply to questions asked by members, Dr. Stewart said that his patient probably contracted the disease while working in the damp cellar three years ago. The patient was slightly worse now than when he commenced the faradic brush treatment.

DR. BULLER here remarked that one eye was a little better, the other rather worse, than when first seen. The patient consulted him on account of failing vision. He found his sight much impaired R. E. V., 20' 100; L. E., 20' 70, with great concentric limitation of the visual fields. The field for colors was constricted in a similar manner, but there was no central scotoma. The optic nerves presented the usual appearance of progressive atrophy from spinal sclerosis. The condition of the eyes, together with the absence of patellar reflex, seemed to warrant the diagnosis of *Locomotor Ataxia*.

DR. OSLER asked if the very early symptoms were pre-ataxic, as it was well known that the eye symptoms often preceded for a long time lightning pains, etc.

DR. R. P. HOWARD said that one of the first cases diagnosed in MONTREAL was one of his patients, who came to him suffering with transient strabismus, his walk was slightly axatic, but there were then no pains, he lived 15 or 16 years, and died in Europe last year. He had myosis.

DR. HENRY HOWARD remarked that he has had several cases under observation where impotency was the first symptom.

DR. OSLER, the past summer, had a patient under his care who had been troubled with double vision, and severe headache for four or five years. He went to London and consulted Dr. Broadbent, who diagnosed and treated him for cerebral syphilis. He got perfectly well, but two years ago *Tabes* began to develop, and now he is in the third stage of *Locomotor Ataxia*.

DR. ROSS said a patient came under his care yesterday in the hospital, who had had the gait symptoms for two years, but till lately had had no eye symptoms at all. At present he is remarkably ataxic, has loss of patellar reflex, no lightning pains. DR. ROSS had asked Dr. Buller to examine this patient.

DR. BULLER remarked that the hospital patient with ataxic symptoms, sent to him by Dr. Ross for examination yesterday, had no loss of vision. His optic nerves, however, did not present a healthy appearance. They were somewhat swollen, and the margins decidedly indistinct, perhaps presenting the condition described by Dr. Gowers as gelatinous infiltration. The bulk of the papilla had a hyperæmic appearance, whilst the temporal side was in part rather unusually pale. On the whole, I think the condition was such as we usually meet with in persons whose vision is beginning to suffer from excessive use of tobacco and alcohol. With regard to the atrophy of the optic nerves met with in *Locomotor Ataxia*, Dr. Gowers has made the observation that when this condition comes on early in the course of the disease, that is, during the first or pre-ataxic stage, the resulting loss of vision is more rapid and more complete than when occurring as a later symptom; this observation coincides with my own experience of such cases. When atrophy of the optic nerve occurs early it must, I think, often be a matter of doubt as to whether the trouble is of spinal origin at all. I know of several cases in which atrophy of the nerves has led to complete blindness, which has now lasted for one, two, or three years without the development of any fresh spinal symptoms, though there has all along been absence of knee-jerk, yet all of these cases have been regarded as commencing *Locomotor Ataxia* by the very highest authorities on the subject, both in Europe and America.

DR. R. P. HOWARD said he had three cases of Locomotor Ataxia at present. In two, there is great contraction of the pupils—one a gentleman, the other a lady. The gentleman has myosis of both eyes, but greater in one. In the third case the pupils differ, there is good vision in one eye, DR. HOWARD remarked that a contracted pupil should make one look out for Tabes. There is great frequency of pulse in one gentleman and in the lady. The gentleman took Hyoscinamin for a long time under Dr. Seguin, with but little effect. DR. HOWARD said a late theory was that this disease was caused by functional excess of a sensory nerve, and that sexual excess was said to lead to it. DR. HOWARD also remarked that out of many cases which he has seen, one only suffered from gastric crisis. Had used the electric brush in the case of the lady, with the result of restoring feeling in some parts of the skin, otherwise no improvement followed.

DR. HENRY HOWARD had used the electric brush for anæsthesia with good effect where there was absence of motor paralysis.

*Lawson Tait's Operation.*—DR. ARMSTRONG exhibited the ovaries and tubes removed by him, a couple of days previous, from a lady, aged 22, who had suffered for three years from pelvic pain. She had menstruation for fourteen days for the past year, suffering much each time; this quite unfitted her for work, and made life miserable. Both ovaries were prolapsed. Patient doing well. The ovaries were both a good deal enlarged.

*Meeting held, December 28th, 1883.*

THE PRESIDENT, DR. RODGEF, in the chair.

DR. WOOD read a paper on "Ether in Obstetrics."

This paper will be found among our original Communications.

Dr. Campbell said that during the past twenty years he has used anæsthetics very little; does not think it wise to give chloroform for hours, as some do; has noticed that the uterus does not regain its power as promptly when this is done. He saw an objection to ether in its smell and its being so irritating to the eye. Dr. Campbell believes the mental condition has much to do with the immunity

from deaths with chloroform at this time. The woman approaches the period for delivery without fear, knowing so many of her friends have safely passed over this trouble, whereas the person to be operated on by the surgeon has a dread, often for a long time before.

Dr. Reed remarked that if there were no deaths recorded from chloroform during labor then chloroform must be better than ether, as it has all the advantages without the objections. The statistics stood thus with regard to mortality: chloroform 1 in 3 thousand, ether 1 in 30 thousand, and gas 1 in 50 thousand.

Dr. Smith believes in easing a woman as much as possible, and has used and will use even for hours, if necessary, an anæsthetic composed of alcohol one, chloroform two, and ether three parts; has never seen flooding follow its use, and feels safe to allow a nurse to give it.

Dr. Trenholme has only used chloroform during labor. With regard to the use of anæsthetics during labor is now more opposed than ever. When called to a woman, and finding the first pains irritable and the os thick and firm, instead of using an anæsthetic for hours he administers 45 minims of laudanum; this gives ease from pain and find they don't recur for a week or even a month, as often these are cases of false pains. Was sent for by a woman who said she had come to full term, but on examining found the above conditions present, gave her 45 m. laudanum; pains did not return for a month, when found her as before; gave another 45 m. laudanum,—she went on for another month, when he was sent for again, and as the indications were present wanted to give another dose, but the woman said she had carried the child for eleven months, and would not carry it a year for anyone. She was delivered two or three days later. Dr. Trenholme said that very tedious long labors left the woman more prone to post-partem hemorrhage. He also remarked that the heart was more fatty during gestation, which would look as if anæsthetics ought to be dangerous in obstetrics.

Dr. Hy. Howard said that in his younger days anæsthetics were not known, and of course not used in midwifery cases, but that in Ireland the pains of labor were often lessened by taking a good dose of whiskey punch, he never saw harm come from it.

Dr. Campbell thought that Dr. Reed's statistics were not strictly true, as he believed there were cases in Montreal where the woman died from flooding due partly to the chloroform used.

Dr. Rodger has used anæsthetics largely always; used chloroform till within a few years; has seen post-partem hemorrhage follow its use. Now uses ether, but finds it not so useful as chloroform for irritable subjects in the first stages; but for such cases he now gives a good dose of chloral. The great advantage ether has over chloroform is that you can dispense with an assistant in an instrument case, and feel perfectly easy while the nurse is giving the ether. In an instrument case before giving either anæsthetic he gives a dose of ergot to ensure good contraction.

Dr. Wood asked if any of the members had noticed whether their epileptics had anæsthetic spots.

Dr. Hy. Howard said that nearly all the epileptics with mania have anæsthetic areas over the body or limbs.

*Mastitis treated with ice*—Dr. Campbell mentioned a case of inflamed breast apparently on the way to suppuration, and beginning in the usual way with sore nipples, which he was treating with applications of ice. The breast, which was very much enlarged, is now terminating by resolution, and is only one half its former size.

Dr. Trenholme said this was an old treatment; that in most cases the inflammation begins in the lacteal sacks and that each opens at the nipple. Hot applications congest and increase the danger of its spreading to other catyledons, but that ice isolates the inflammation.

Dr. Campbell related a case where he had confined a woman and left her well; in three weeks he was sent for, as the baby was vomiting pus. On squeezing pure pus came out of both nipples. The breasts were poulticed, and in 36 hours they looked like two bags of matter and discharged enormous quantities.

Dr. Campbell confined this same person lately, and now she nurses well from both breasts.

Dr. Trenholme reported that one of his cases of removal of both ovaries and tubes, operated on three and a half months ago, was now able to enjoy life thoroughly; she skates, and recently had walked seven miles.

## Progress of Science.

### CLINICAL LECTURE.

By G. M. LEFFERTS, M.D., Clinical Professor of Laryngoscopy and Diseases of the Throat in the College of Physicians and Surgeons, New York.

Before entering upon the subject of our lecture to-day, I would make a remark with regard to a man who presented himself at our clinic two or three weeks ago with a ten cent piece in the pharynx, for doubtless you will be interested in hearing the result. I told you at the time that of course the first surgical procedure was to undertake to get the foreign body out by intra-laryngeal methods, take some form of forceps and grasp the ten cent piece and gradually withdraw it. Should the body be found to be so impacted that it could not be removed in this way, then open the air tube at the crico-thyroid space, the same as in laryngotomy, pass in forceps curved upward, seize the coin and withdraw it through the artificial wound made, and then bring the edges of the wound together by sutures. That was what we proposed to do. Two or three times the coin was grasped, but each time the instrument slipped. It was difficult to get an instrument which would catch it at the right point. On the following Friday, this being on Thursday, the man had a violent attack of coughing, and coughed the coin up. The coin disappeared; the man then looked for it, but could not find it. He probably coughed it up into the mouth and swallowed it.

I am going to talk to-day about the subject of chronic nasal catarrh, a subject, as I have already said, of interest to all medical men because they see so much of it. Patients will come to you, having made their own diagnosis of nasal catarrh, and insist upon it that you treat them for that affliction. They imagine from descriptions given in quack books on nasal catarrh, etc., that they are going to take on the bad smell there described, and insist upon it that you must treat them and prevent it.

Now, if the patient have the disease, it is not likely that it will proceed to the extreme form of fetid catarrh, which is still more rare than ozæna, and I believe, as I have before said, that ozæna has nothing to do with nasal catarrh. It can only occur in the syphilitic patient whose nasal bones are necrotic, and where the diseased organ keeps up a constant fetid discharge and a nasal catarrh, and sets up a stinking there, the same as a diseased bone will do in any part of the body. The same thing may happen in scrofula. Under these two circumstances, then, you may have this fetid, stinking disease, but only under these two circumstances. Ozæna, understand me, is never nasal catarrh. The only form of nasal catarrh that can be stinking is that form which we designate atrophic or fetid catarrh. We no longer call everything nasal ca-

tarrh. It is an incomplete, unsatisfactory diagnosis, and I never want a physician to make a diagnosis and tell me it is nasal catarrh. If he doesn't know what form of nasal catarrh it is, then he is ignorant of the subject in hand. He doesn't know how to treat the case. Call it one of the forms of chronic rhinitis. These forms are three in number.

First, ordinary, simple nasal catarrh—simple chronic rhinitis. These persons are not likely to go to the doctor, for they are not troubled much with the symptoms, and they put it off day after day, week after week, and month after month, until the simple form becomes a chronic nasal catarrh. This process, I say, goes on, and causes pathological changes; the mucous membrane becomes thickened, it becomes hypertrophic, and narrows the nasal passages. This is the form of the disease which you will be called upon to treat. The symptoms become more or less annoying, the patient notices that there is something wrong with his nasal apparatus, and he comes to you for relief. Now, you can do an immense amount of good for that patient. You can cure this form of disease, and add greatly to your reputation.

But, suppose the patient does not heed this form of the disease, and allows it to go on. Then the hypertrophy of the mucous membrane becomes permanent, and begins to contract, as fibrous material will do in any part of the body, especially where it is left after a chronic inflammatory condition. It contracts, and as it contracts it draws the mucous membrane down upon the bony walls. It obstructs the numerous little glands which keep the parts soft and pliable by the secretion of mucus. The parts become dry and harsh, and the scanty mucus, now changed in its character, becoming muco-purulent, constitutes clots in the nasal passages. It scabs over passages, mucus is poured out beneath the scabs and remains in situ, decomposes and stinks, and the patient is in the condition of foetid nasal catarrh. It is one of the results of the disease.

The second result is that it causes atrophy of the turbinated bone; atrophy of the structure upon which this mucous membrane lies. Such a condition in atrophic or the foetid form of nasal catarrh is always accompanied by an extra wide nasal passage. This fact is of assistance in diagnosis. When you see an abnormally wide nasal passage, so that, as in some cases, you can look directly through either nasal passage into the pharynx, and you find an impact dry membrane, and hard, greenish-yellow discolored pus pent up beneath it, you can make the diagnosis at once; it is that of atrophic or foetid catarrh. This form of disease, gentleman, is very rare, and only occurs as a consequence of other forms of the disease where they are allowed to go on for months or years entirely neglected by the physician.

Chronic rhinitis, ordinary, simple, every-day chronic inflammation of the nasal mucous membrane—what we call the simplest, the mildest, the

most unobtrusive, form of nasal catarrh. There is the one symptom, and that is a discharge of mucus. The glands are involved in the chronic process, and their walls throw out a free secretion, which is simply hyper-secretion of mucus, loaded down perhaps with cells. I say that in this form of simple chronic catarrh there is simply a hyper-secretion from a chronic inflammation of the nasal mucous membrane. There is no thickening yet of the mucous membrane; there is no hypertrophy of it; and, consequently, there is no stopping up of the nose which changes the voice more or less, and makes one uncomfortable because of the difficulty of breathing through one or the other nasal passages; and, consequently, no interference with smell or perception of savor. There is simply a recurrence of cold in the head; a susceptibility of the mucous membrane to cold, and the patient must use the handkerchief or draw the secretion down the throat. This is the whole story. Now, when patients come to you to be treated for this affection you must be able to diagnose it, and be able to tell the patient exactly where he stands in the pathological scale, so to speak.

You must remember that this disease may lead to another form, and you must let your patient know that you cannot cure him if he persist in exposing himself to the cause. And, also, let your patient be convinced at once that you cannot cure him in as many days as the disease has existed for months or for years; that time is requisite, and if he will give you an opportunity to make regular systematic applications to his nasal catarrh such, all, nasal catarrhs, can be cured.

Now, what are you going to do for the patient? In the first place, cleanliness is absolutely essential. What earthly use is there to apply medicated solution, or a medicated powder, to the mucous membrane in the hope of medicating it, when it is covered up with a film or layer of mucus? The next moment the patient blows his nose, and out comes the application which you have made. You have done no good.

I say absolute cleanliness in this form of nasal catarrh, and in all forms of nasal catarrh, is absolutely essential. It is the foundation of the whole matter of treatment. It is the corner-stone. On the other hand, the nasal douche, as generally sold at the drug stores, is utterly useless. A few years ago these instruments were used ten times as much as they are at present. In other words, we know that it is not necessary to use these instruments in this class of cases as often as we did five or ten years ago. I hold that the use of a high pressure of water through the nose is unnecessary. The patient may think it necessary, and some may so treat him, but this all wrong. In the chronic or foetid form of catarrh the patient is unable to blow out the plug of dried-up secretion, and it is absolutely necessary to do something which will aid in removing them, but in this simple form of chronic rhinitis I believe more harm is being done than good by the use of these instruments for washing

out the nasal passages. The mucous membrane is inflamed, and if you pass over it a stream of water under pressure you will keep up the state of chronic inflammation. Many times I have seen chronic inflammation of the nasal passages caused by the injudicious use of the douche or of medication. But there are also cases of even simple chronic rhinitis where it is necessary to wash out the passage. Make your examination with the nasal speculum anteriorly, and you will see there simply a reddened mucous membrane—no hypertrophy, no thickening, no plugging up or stoppage of the nasal passages. Look and see whether the nasal passages are clean. See whether there is thick mucus, and, if so, you must give the patient something that will remove it. But if he keeps the mucous membrane perfectly clear and free by blowing the nose, so that the medicine will reach it, then a cleansing apparatus is not required. If it is necessary to wash out the passages, then give the patient the necessary apparatus to do it with, and have him use it properly, and only as you direct. Do not give patients a post-nasal syringe, and tell them to use it, and allow them to go on using it when they please, washing out the nose perhaps five or seven times a day.

Now, what apparatus shall you recommend to your patients? Here, gentlemen, is the best apparatus that I know of for the purpose. It is simply a spray, as you can readily see, and let me say at once that the nasal douche has long proved ineffectual in cleansing the nasal passages. The upper part of the nasal passages are never, or are very rarely, washed by the ordinary nasal douche. The post-nasal syringe is extremely inconvenient for use. The majority of patients will not use them. The best means for cleansing the nasal passages is the coarse spray. This washes up the secretions, and you could accomplish with very little fluid in such an apparatus what it would take a great deal of fluid not to do with the nasal douche. In using the spray the patient must breathe through the mouth, and thus the whole nasal passage and vault of the pharynx are cut off from below. As long as the attention is kept on the breathing the velum will remain up against the post-pharyngeal wall, and the fluid will not pass downward into the throat, and thus the spray will rush about in all directions where it is desired. Then let the patient lean forward and blow the nose gently, never hard. Never hard, I repeat, because the fluid may be blown up the Eustachian tube and cause inflammation there. Here, then, gentlemen, is a marked advance in the cleansing process over the use of a quart of salt water in a nasal douche. This apparatus will do the work, do it effectually, gently, and a great deal better than any nasal douche ever did it. You may use, as a cleansing solution, the following receipt :

R. Acidi Carbolici..... ℥i.  
 Sodæ Bicarbo.....  
 Sodæ Biboratis.....

Aquæ Rosæ aa..... ʒi.  
 Glycerinæ..... ʒi.  
 Aquæ, ad..... Oj.

It may be necessary to use this prescription every day or perhaps only twice a week. Remember that the cleansing process is only preparing the way for the use of your medicated application.

Now, what are you going to use as an application? We must be careful not to do too much; not to cause an inflammation. I would lay it down as a cardinal rule that no cleansing, no application or medicament made to the nasal passage should ever cause the slightest amount of irritation. The patient should be made comfortable, and not uncomfortable by the application, for hours or the entire day. If the patient feel uncomfortable it is a sign that harm has been done rather than good. Never make application too strong or repeat it too often.

A second point, one that is to remember distinctly, is that the nose will not stand an application which the pharynx or the larynx would stand. In other words, the same strength solution which you could apply with immunity to the pharynx, or even to the larynx, would not be borne for one moment by the nasal mucous membrane. It would give the patient pain. Therefore, always commence with a light, mild application, studying to adapt the strength of the application, to each particular case in hand.

Now I will give you an application which may be used in this form of the disease, or in the next form which I shall mention, in which hypertrophy has commenced, an application which I use perhaps more than any other. You may, however, use any of the ordinary mild mineral solutions, if you please, but make them mild. Those which are applicable for the pharyngeal mucous membrane may be used for the nasal mucous membrane, if you will make them sufficiently mild.

Now, how shall you use them? By the spray; if you have no other form of apparatus you can use the one here. If, however, you have another form, whereby you can get the spray behind the velum, and spray upward into the posterior nares, thence forward into the nasal passage, you can make a much more thorough application than you can possibly do by the anterior spray. But if you cannot get this, then use the anterior spray, driving it backward. I say that any one of the astringents in the pharmacopœia may be used, but the following is that which I use most. This is to be used, of course, after the nasal passages have been thoroughly cleansed, if cleansing is necessary.

R. Iodine Cryst..... gr. iv.  
 Iodid. Potass..... gr. x.  
 Zinci Sulph. Carbolate.....  
 Zinci Iodid. aa..... ℥i.  
 Listerine..... ʒ viii.  
 M. Ft. Lotio.....

Now what is Listerine? you will naturally ask. It is a preparation lately put upon the market, which makes a very pleasant menstrum for this mixture. It contains boracic acid, and has an odor of wintergreen, which is very pleasant and agreeable. It is antiseptic and disinfectant. It is entirely unirritating to the mucous membrane, and containing boracic acid, it is healing in its properties.

The application of a powder sometimes will answer a very good purpose, if the secretions are soft and fluid, so that the powder will be absorbed by them. In cases where crusts form on the nasal mucous membrane, and the parts are dry, you should never use a powder; but where the parts are soft, moist, and there is plenty of secretion to take up the powder, it probably remains longer in contact with the mucous membrane than a solution used as a spray. You can use alum, or tannic acid, and apply as you like. Here is a powder blower for the purpose, which can be used from the anterior or posterior nares.

Such, gentlemen, is the treatment according to the indications in ordinary chronic rhinitis and certain grades of hypertrophic nasal catarrh. I have told you that hypertrophic nasal catarrh exists when hypertrophy has taken place in the mucous membrane, and all the glands at the vault of the nasal pharynx are involved concomitantly. This hypertrophy blocks up more or less completely the inferior portion of the nasal passages, the hypertrophy taking place over the inferior turbinated bones; very rarely over the superior. Since there is also hypertrophy over the vault of the pharynx it is better to make the application through the posterior nares rather than through the anterior nares alone.

But after a time there is no use of treating a case in this way. A patient comes to you and tells you that one or other of his nostrils is continually blocked up, you look into the nasal passages, and instead of finding it roomy on both sides, you find a large, irregular, thick mass. You find, perhaps, if you make an examination posteriorly, that there is a condition of the posterior part of the turbinated bone which almost completely blocks up the nasal passage. If in such cases you follow the above simple plan of treatment you will throw so much time away. There is only one thing in such a case that you can do, and that is to treat the case surgically, and by so treating it you will gain an immense amount of credit: you will get the credit of curing an extreme case of nasal catarrh. In such a case, I say, you will see on looking into the nasal passage, a round, thickened piece of mucous membrane rolling out into a great round fold, as it were, and you infer at once that it is hypertrophy of the mucous membrane; and by the side of it you see a very narrow, sometimes a completely closed, channel; and above, perhaps, you see the middle turbinated bone swollen out in a similar manner. Now, if you take a probe and press upon this mucous membrane, instead of finding it in a normal condition, you will find that

it recedes deeply, and shows no signs of elasticity. In such a case you want to relieve the obstruction to the passage of the air to and through the patient's nose, for this is the symptom of which he complains.

Now, here is an operation which you can all do. It is to illuminate the nasal passage, and take a tick as it were, in the mucous membrane; and when a scar forms it will draw down the membrane, and hold it there. When operated upon in that way, the patient is rarely if ever again troubled in the same way. Take a small bit of cotton, and roll it about a cotton holder in this way, so that a small wad is made; dip this into fuming nitric acid, press out the excess of acid so that there shall be no danger of its dripping on the patient's lip or the passages; then dilate the nose widely, throw a strong pencil of light from the forehead mirror into the nasal cavity; now burn an ulcer on the swollen mucous membrane, so that it shall contract and draw the parts back into place, then make an application of an alkali, so as to neutralize the acid, and the operation is done. There has never, in my experience, been any return of the disease after a single application of the acid. Now, I know, gentlemen, of no single operation in the whole range of nasal surgery which will do as much good as this one. The operation is painful only for a moment. Some prefer glacial acetic acid to nitric acid. The hypertrophied membrane over the inferior turbinated bone may be removed by passing what is called jarvis snare through the nasal passage into the pharyngeal space, bringing it down over the hypertrophied mucous membrane, encircling it and bringing it home. It is intended to cut the hypertrophied tissue very slowly, so as to avoid hæmorrhage.

Atrophic nasal catarrh I believe to be incurable. All that you can do is, by thorough cleansing of the nasal passages by the solution in spray, to keep the parts clean, prevent the secretion from decomposing and causing fœtor. Do not tell such patients that you can cure them, but that you can relieve them by keeping the parts clean.—*Nashville Journal of Medicine*.

## ABSTRACTS FROM A PRACTICAL TREATISE ON DISEASES OF WOMEN.

[Translated from the French of Dr. G. Eustache by THOMAS C. MINOR, M.D., Cincinnati, O.]

### PART FIRST—MEANS OF DIAGNOSIS.

The study and the diagnosis of the *diseases of women* requires a special series of manipulations and explorations with which the practitioner must become familiarized. These methods of investigation, or rather of diagnosis, so far as regards absolutely special methods applied to gynecological inquiry, are few in number, *i.e.*, four—1st, digital examination; 2nd, the speculum; 3d, uterine catheterism; 4th dilatation.

In the first chapter will be discussed some of the general considerations relative to the means employed in conducting a gynecological investigation and making a correct diagnosis, such a preliminary course being necessary before resorting to treatment.

#### CHAPTER I.—GENERAL CONSIDERATIONS.

The nosological determination of the different morbid affections of women is surrounded by very great difficulties, hence, errors in diagnosis are frequent; these errors may consist, not only in confounding two maladies of the same organ, but also in mistaking two diseases having absolutely different situations and points of origin.

Many of the diseases of women are dependent on an anatomical or functional derangement of the various portions of the genital apparatus and belong, properly speaking, to the domain of *gynecology*, constituting what is commonly designated under the name *diseases of women*; the lesion is local, the disturbance more or less general. But the primordial lesion, by the date of its appearance and the persistency or intensity of its special symptoms, necessarily attracts the attention of the patient and the physician, and its seat, if not its nature, is very easily determined.

But in a very considerable number of cases the inverse occurs; the general symptoms are developed, and have acquired little by little a very great intensity; the local symptoms are null or nearly so; the patients, if they are unmarried or childless, will not admit of the possibility of a disease of the genital organs, and refrain from calling the attention of the physician thereto—growing offended if their medical attendant presumes to question them upon delicate points, and continuing to complain without ceasing of the existence of disease of the stomach, lungs, brain, etc. They may be possibly right in this, as they may be wrong. It is the physician's duty to recognize, amidst this maze of contradictory statement which professional politeness requires him to listen to patiently, the true condition of the woman.

Finally, it may happen that any disease, following its usual progress, may induce consecutive modifications in the functions of the genital apparatus—modifications that assume exceptional and even capital importance in the eyes of many patients when they have (in reality) no significance. If the physician, under such circumstances, does not discriminate between what is told him and that which his own skill determines, he will fail in his diagnosis and be disappointed, for instance, by treating a leucorrhœa or uterine granulations when his patient is purely and simply consumptive.

The *diseases of women* may then be the subject of many errors, 1st, they may be unrecognized when they exist; 2d, they may be admitted when not existing; 3d, they may co-exist with other affections more or less obscure, the correlative importance of which it is most often difficult to determine.

The physician, called under such circumstances, must surround himself with all the means possible in order to determine the truth; there are two methods to be necessarily employed which both possess great importance, 1st, *interrogation*, from this he will learn *the history of the patient*, which will make him acquainted with all the *subjective symptoms* that have existed or still exist; 2d, the *physical examination* of the genital organs and the neighboring parts, which will exhibit the *objective symptoms*. It is only by exactly following this method that our information will be complete, and merit the title of a real clinical observation.

*Interrogation of Patients.*—Asking questions properly is a very difficult thing to do; women have a multitude of details to describe and are prolific in information, and the physician will be unwelcome in the majority of cases if he attempts to cut short the usual prepared narration; he must submit quietly, as it is important for the doctor to gain the confidence of his patients for the purpose of finally obtaining the answers he desires, and especially inducing them to submit to the necessary physical examination. If this method is followed the physician can soon ask the questions himself and pursue his interrogations systematically without being diverted from the subject of his inquiry. The answers are from thence, more clear, more precise and much less liable to lead into error.

As a general rule, after having taken the name of the patient, her age and social condition, the physician is informed of the malady for which he is called, of the nature of the pains experienced, of the date of their first appearance, of the progress of the disease, etc. He should insist on the patient describing her present condition, and allow her to afterwards describe her anterior condition of health and the subject of heredity. If the physician is led to suspect a disease of the genital organs, he should none the less, before pushing questions too far on that point, study the condition of the different systems, nervous, respiratory, circulatory, digestive, in a word, explore and know the significance of the modifications or functional and organic troubles of the economy.

It is always of the highest importance in treating the diseases of women, to be fully informed as to the manner in which the functions of the bladder, rectum, pelvic organs, muscles and nerves are performed. After investigating these different points, questioning as to the condition of the genital organs should be resumed; it is very important to interrogate the patient, particularly as to what is called her sexual history, that is to say menstruation, inter-menstrual discharges, pregnancies, and even in certain cases as regards her sexual relations with man, that which the English designate by the name of *parenina*.

Under the head of menstruation should be noted the first appearance of this discharge, whether it has been regular or irregular from the time of its establishment, the duration and the quantity of the

flow—and finally, if the woman is advanced in years, the date of its cessation. Menstruation in place of being normal is morbid; it may be in excess (menorrhagia), or deficient in quantity (amenorrhoea), or it may be accompanied by pain (dysmenorrhoea), which sometimes precedes, sometimes follows and is sometimes in a manner continuous.

Intermenstrual discharges are no less important to note. Their quantity, quality, order and persistency, and finally, under some circumstances, their chemical and microscopical properties should be successively investigated.

Anterior pregnancies, their number, their date, and principally the first and last accouchments, the duration of the labors, method of delivery, whether natural or artificial, the after puerperal conditions, the development of the lacteal function, and all the consecutive order of things relative to childbed, including the time spent in bed before returning to ordinary domestic avocations, are all circumstances which tend to throw light on the history of either uterine or periuterine maladies. Precisely the same attention should be devoted to the question of previous abortions and the conditions preceding or following such accidents.

The physician should be extremely cautious in asking his questions relative to sexual connection, and such interrogation should only be followed in cases of absolute necessity.

The pathological and sexual history of a woman thus carefully studied will seldom fail to reveal the localization of the disease in the organs contained in the lower pelvis and particularly in the genital organs. It is necessary to recognize, however, all those signs which are only probable. If we desire to acquire more exact information, to precisely localize the disease and separate it from other affections of the same organ or the same apparatus, it is absolutely necessary to resort to a direct exploration of the parts, as they only can give the *certain* evidences of the malady.

II. *Physical Exploration.*—Exploration of the genital apparatus is *external* or *internal*.

The first consists in investigating the condition of the parts situated in the hypogastric region and lower pelvis, by *inspection, palpation, percussion, auscultation, mensuration*, etc., that is to say by a series of methods applied to the surface of the skin. We commence our investigation in this manner, and patients offer but few objections and usually submit.

The second method (*internal*), on the contrary is followed within the natural orifices, so that the intra-pelvic organs are directly investigated; the condition of these organs is ascertained in various manners, to the end that we may afterwards more exactly appreciate their physical condition. It is evident that *internal* exploration is without doubt that which will furnish the most positive information, and that by following this method we not only are able to make an absolute diagnosis of a disease of the genital organs, but also a *differential* diagnosis of all such diseases.

But if internal exploration is necessary, it is very often difficult to obtain the consent of the patient, who has a natural repugnance to such a procedure. Under such circumstances the physician must employ an extremely delicate tact to overcome the usual feminine objections, and thus induce the woman to tolerate the examination without absolutely demanding the favor.

The following lines, quoted from Gallard (1), will serve as a guide in all such cases:

“Remember that it is always necessary to obtain the consent of your patient and avoid demanding such a privilege. If you are a young physician resort to circumlocution and tact in asking such a privilege from a young woman, whose sense of modesty will be shocked and whose feminine feelings will revolt at the bare mention of the method to be employed. If the examination be demanded under such circumstances an irrevocable refusal often follows. When you can convince her to the contrary by your attitude that the examination desired is nothing unusual in such cases; if you will maintain a calm and dignified professional air; if after feeling the pulse, auscultating the lungs and heart, you touch the belly and simply and naturally say that it is necessary to practice the touch, the woman will never dream that back of the physician who examines her she might find a man, and will unhesitatingly submit herself to all the examinations which a doctor deems essential.

In all cases remember the axiom, the physician should never impose an examination on a patient unless such a procedure is absolutely necessary. The physician who respects himself will only ask for that which is judged indispensable, and after making the request he must not allow a non-compliance with his wishes, if he does not desire to lose all moral authority over his patient. In the face of an obstinate refusal there is only a single line of conduct to be followed; this is to absolutely refrain from prescribing any treatment, and by pursuing such a course of action make his patient understand that such action is based solely on the ground that it is impossible to successfully combat a disease whose nature is unknown, and that treatment in such a case would not only be unsuccessful but even perhaps injurious. It is likewise necessary to carefully avoid making too persistent entreaties in order to induce the patient to decide and then reproach her for a refusal to submit to your examination. A cold and reserved, but at the same time a kindly, attitude is the only position to be worthily maintained in such an emergency. It is only by assuming such an air that a woman will be led to understand how exaggerated her scruples are, and thus induce her to repent her previous determination.”

These councils and precepts are too important to be omitted from this chapter,

1. Gallard, *Leçons Cliniques sur les maladies des Femmes*. Paris, 1879.

III. *Methods of Exploration.*—The various methods of exploration which may be used for examining the internal as well as the external genital organs of women are furnished by the different senses, but especially by the touch, the eye and the ear, and may be classified in the following manner :

1st. Touch	Immediate	Abdominal palpation.
		Percussion.
1st. Touch	Mediate	Touch { the vagina. the rectum.
		Double touch (the vagina and rectum touched at the same time.)
		The vaginal touch combined with abdominal palpation or bimanual exploration.
2d. Sight	Immediate	Inspection.
		Speculum.
	Mediate	Examination of liquids drawn off by aspiration.
		Microscopic examination of liquid and solids taken from parts affected.
3d. Hearing	Stethoscope	Sounds depending on pregnancy.
		Sounds depending on circulation in fibrous tumors.
3d. Hearing	Immediate	Crepitation.
		Mediate

#### CHAPTER II.—TOUCH.

The touch, that is to say, the exploration of a natural cavity by the aid of one or more fingers properly introduced in the rectum or vagina alone, or in both cavities at the same moment, it may be employed singly or combined with abdominal palpation. The following divisions in which this method may be usefully employed may be thus enumerated:

- 1st. *Simple vaginal touch.*
- 2d. *Vaginal touch combined with palpation or bimanual exploration.*
- 3d. *Rectal touch.*
- 4th. *Double touch, vagina and rectum are touched at the same moment.*

Within a recent period, Weiss and Simon have insisted on the merit of the *vesical touch* or the *digital exploration of the bladder.*

I. *Vaginal Touch (Simple).*—*Position of the Woman.*—The vaginal touch is practiced with the

woman either standing on her feet or reclining on a lounge. Under some circumstances the examination should be made in each of these positions, for the purpose of exactly appreciating the situation of the organs and the modifications induced by the influence of gravitation; however, the examination in the standing posture should be the exceptional one, and may be considered as a complimentary measure.

In order to practice the touch standing, the woman should support herself against some piece of furniture, the thighs moderately separated, the body inclined forward in such a manner as to relax the abdominal muscles; a very good plan is to have the patient lean forward holding on the back of a chair, resting her hands upon the shoulders of the examining physician who is on his knees before her, or seated upon a low stool.

In order to practice the touch where the woman is reclining, we have to choose between the different positions. The best and most simple of methods consist in placing the patient flat on her back, the thighs slightly flexed upon the abdomen and moderately separated, and the head raised by a pillow; it is also advisable not to permit the pelvis to sink very deeply into too soft a mattress as, when this happens, the hips have to be raised up again and supported by a bolster.

This is the position almost universally adopted in France and the European continent and likewise in America.

The English prefer the *left lateral position*, that is to say, the woman rests on her left side with the thighs slightly flexed upon the abdomen; this is also the English position in childbirth. But if this position presents some advantages in the exploration of the posterior part of the pelvis, it offers serious inconveniences in the examination of other portions and, moreover, cannot be used for the simultaneous application of abdominal palpation, and should, therefore, be rejected as a general rule, or at least only resorted to in certain special cases. If this examination, when completed, is to be followed by other methods of exploration, the woman should lie across the bed, as in that position the speculum is commonly used.

*Method of Proceeding.*—The woman being placed in the sacro-dorsal position, the surgeon, after anointing the index finger of his right hand with some fatty substance, such as olive oil, glycerine, comoline, or vaseline, raises the bed-covers slightly with his left hand and carries the right hand and forearm forwards between the thighs of the patient, in such a way that his right elbow may rest slightly upon the bed; this movement may be made without uncovering or exposing the woman.

At the moment when the right hand is thus passed under the bed-clothes, the thumb is abducted, the index finger stiffly straightened, and the three remaining fingers flexed in the palm of the hand, which rests on the side, its radial

border turned forward, its cubital edge backwards. The hand is then carried forwards following the internal and posterior face of the right thigh until the index finger touches lightly and rests upon the perineum. At this point the wrist should be made to describe the arc of a circle from the back forwards and the tip of the index finger will glide over the perineal plane and reach the fourchette which it passes and gently drops into the vulvar orifice.

After the finger enters the vulva, it is carried forwards following the anterior wall of the vagina, passing to its full length until it reaches the neck of the uterus. During this progression, the thumb is gradually relaxed in such a way as to lodge its length in the right crural folds; while the three disengaged fingers are gradually extended and directed forwards, the inter-gluteal folds and finally the commissure which separates the index from the middle finger comes to embrace the fourchette. This change in the position of the fingers is very advantageous and very important, for the index finger may be thus more deeply inserted; the perineum and soft parts may be forcibly raised, and it is rare, even with fingers of medium length, that we are not able to reach in this way the promontory of the sacrum (sacro-vertebral articulation).

The finger on touching the bottom of the vagina, meets the neck of the uterus, at which point it is easy to examine the anterior lip, the orifice, and the posterior lip in all their circumference, appreciate its size, situation, consistency, then the finger may be passed into the left lateral cul-de-sac, the posterior cul-de-sac, the right lateral cul-de-sac and finally forwards into the anterior cul-de-sac. During these various examinations the hand executes a movement of circumduction, in such a way that the tip of the index finger should be always turned towards the point to be explored.

It is often useful, at the moment of exploring the various cul-de-sacs, to press strongly upon the perineum in order to raise it up as high as possible, to the end of reaching the highest points, even those situated beyond the vagina and uterus, up to the entrance of the abdominal cavity.

When the exploration of the deep parts is terminated we bring the index finger forwards in order to learn the condition of the anterior vaginal walls, the bladder and the urethra; the finger is then carried backwards against the posterior vaginal wall, which surface is explored its full length, and the finger, finally, slowly withdrawn.

The touch practiced in this manner, is sufficient in the majority of the case; it is applied to all circumstances, to all diseases; it is an easy method of examination, applicable even to *virgins*. However there are certain cases where the introduction of two fingers, the index and the middle simultaneously, presents certain advantages by allowing us to explore more deeply, and thus permitting us to appreciate more exactly the size, weight and mobility of the uterus, when we resort

at the same time to abdominal palpation practiced with the other hand.

Touch is generally practiced with the right hand; there are cases, however, where it is necessary to use the left hand, owing to the position of the bed, or by reason of the seat of certain lesions; so a surgeon should be *ambidextrous*.

*Information Furnished by the Touch.*—In order to clearly appreciate the information furnished by the touch it is absolutely necessary that the physician should have had a long experience with examinations of perfectly healthy women; when this is the case the information desired is invaluable, and we reiterate the opinion that of all methods of gynecological investigations the touch is the most important, that it is necessary to resort to it in all cases, and which should, in case of need, supplant all others. In fact, by means of touch, there is no organ whose healthy or pathological condition cannot be completely appreciated and understood.

The sensibility of the vulva, its irregularities of surface, its congenital or acquired narrowness, spasmodic contraction, etc., are almost immediately revealed. The dimensions of the vagina, its length, temperature, spasmodic or fibrous contractions, sensibility, condition of tumefaction, softness, induration, dryness or moisture, and even the presence and nature of tumors, may all be readily discovered. The uterus may be almost completely explored, not only in its intravaginal portion, but also in the sub-vaginal portion of its neck and body. The finger carefully passed over its surface perceives the volume, consistency, sensibility, situation and the mobility or fixity of the uterus, as well as its smooth, wrinkled, depressed or protuberant characteristics. The orifice of the womb may be explored and all its peculiarities noted; we can even, in certain cases, penetrate its interior and discover the irregularities of its mucous membrane and of the tumors projecting from its surface, following pedicles to the seat of their implantation at points more or less close to the fundus. Across the various cul-de-sac, the finger perceives the condition of the body of the uterus, and we are often able to determine its size, its direction, more or less abnormal, its fixity, its adhesions, and, in addition, various organic degenerations.

This method of exploration also enables us to determine more exactly than any other the condition of the large ligaments, the pelvic peritoneum, the fallopian tubes, and even the ovaries.

In a word, the vaginal touch is the arch-stone of gynecological diagnosis; the precious information it furnishes us is better, more complete, and more precise when, after having employed the method alone and learning all it teaches, we add to it abdominal palpation, and resort to what the English designate by the name *conjoined examination*, that which I shall term *bi-manual exploration*.

*II. Bi-manual Exploration.*—The woman lying extended on her back, the surgeon practices the

touch with the right hand, and at the same time places his left hand on the patient's abdomen at the level of the umbilicus, while the right hand is engaged in exploring the deeper internal parts, the left hand is gradually passed downwards towards the pubis, and the fingers progressively depress the abdominal walls as in hypogastric palpation, being forced as deeply as possible into the cavity of the pelvis.

If the woman is thin and docile, this double manipulation is very easily accomplished, and the exploration of the uterus, especially, can be made absolutely complete. To succeed in this, the movement of the hands should occur simultaneously. The finger in the vagina, applied to the neck of the uterus, should be pushed upwards and backwards, so as to hold the womb firmly, while the left hand depressing the abdominal walls, and dipping deeply into the cavity of the pelvis, rests upon the back of the organ. The distance separating the two hands measures the dimensions of the womb, almost as exactly as could be determined by a necroscopic examination; at such a moment we can perceive the situation, surface irregularities, etc., of the organ examined.

In a general way, the uterus being in a state of physiological anteversion, the vaginal finger pressing not upon the inferior extremity of the neck, but upon its anterior wall, which is pushed upwards and backwards, determines a rocking movement in the inverse sense of the body. The fingers pressing upon the hypogastrium pushing its posterior face, and the distance that separates the two hands, indicates the thickness of the body of the organ and its true dimensions.

In case of deviation of the organ, it may happen that the uterus cannot be felt between the fingers of the right and left hand, which often seem to touch each other; we then investigate some other point in the pelvic cavity; this condition of affairs is most frequently found in the case of uterine flexion and notably in retroflexion, when the uterus is compressed between both hands, an elevating or lowering movement may be effected which will enable us to judge as to its partial or total mobility, either upwards, downwards or sideways. We are likewise able to determine by the sensations of pain developed in such movements the inflammatory alterations or reflex sensibility of the various portions of its suspensory ligaments.

By the same combined exploration, pressing always along the median line, we can learn the state of the bladder, and especially of the anterior and posterior cul-de-sac, note their condition and determine the presence of tumors. The vaginal finger perceiving the tumefaction which is held *in situ* by the left hand applied to the hypogastrium.

On the sides of the womb there are no organs to interfere, so the finger may be pushed along the lateral portions of the neck of uterus until it meets the fingers applied externally to the hypogastrium in such a way that the two hands feel each other;

in a healthy condition of the uterus nothing will be perceived.

If during this examination any foreign body is felt the surgeon should carefully investigate its nature, consistency, sensibility, and determine its seat and point of origin. Sometimes it may be a displacement of the uterus, sometimes a tumor of the large ligaments, and sometimes a disease of the fallopian tubes or ovaries. Ovarian lesions at their commencement can only be determined by bi-manual exploration, which not only reveals their existence, but enables us to establish their relation with neighboring organs, that which is of great importance viewed from an operative standpoint.

If we wish to make a detailed and complete examination, it is necessary to practice the vaginal touch with the right hand and hypogastric palpation with the left, in order to explore the median region and the right lateral half of the pelvis; on the contrary, if we wish to explore the left lateral half and the ovary on the same side, we should practice the touch with the left hand while the right hand is engaged in exploring the abdominal wall.

In conclusion, bimanual exploration is absolutely necessary in order to diagnose diseases of the uterus, fallopian tubes, ovaries, large ligaments and the pelvic peritoneum, and it is difficult to learn anything unless we resort to this combined examination each time that we practice the vaginal touch.

*III. Rectal Touch.*—The rectal touch should only be practiced in case of absolute necessity when the vaginal touch has discovered a uterine displacement or a pelvic tumor, the characteristics of which are obscure. The best thing to do under such circumstances is immediately to proceed, without warning the woman, to make the rectal touch—as if it were only a necessary part of the examination. The finger slowly withdrawn from the vagina is pushed rapidly into the rectum. The patient is perhaps slightly astonished, but the little emotion created soon passes away, and the examination is completed before the woman has a chance to offer any opposition. (Gallard.)

The pulp of the finger is directed forwards and passes over the anterior wall, across which it easily explores the genital organs, all of which are situated in front of the rectum. Thus, after passing the sphincters and entering the rectum the finger encounters in front a hard, smooth, rounded tumor, which is the neck of the uterus, and passing on to the posterior face of this organ we are enabled to examine its slightest peculiarities and penetrate the pelvic cavity even higher than by the vaginal touch. The flexions or curvatures of the womb, tumors having their seat on its posterior wall or those occupying the cul-de-sac of Douglas, are most easily examined, especially if we combine with the rectal touch hypogastric palpation, in the manner heretofore indicated. By the rectal touch we can most easily examine the ovaries.

It has been proposed to substitute the rectal for the vaginal touch in *the case of virgins*, to the end of not shocking modesty and preserving the hymen intact. This substitution, advised notably by Lisfranc and Scanzoni, has not been generally accepted by gynecologists.

Professor Simon, of Hiedelberg, has advised, in certain cases difficult to diagnose, the insertion in the rectum not only of one or two fingers but also the entire hand up to the wrist, a procedure originating in veterinary medicine, and which has caused death in several cases owing to the destruction of the walls of the intestine. The Simon's method should therefore be discarded.

*Double Touch.*—The vaginal and rectal touch may both be practiced at the same time—to the end of more closely examining the recto-vaginal septum, the retro-uterine cul-de-sac—and thus discover any tumors situated in these localities. For this purpose different processes may be used, to wit :

1st. The index finger of one hand is inserted in the vagina, while the index finger of the other hand is inserted in the rectum.

2nd. The thumb of one hand is inserted in the rectum, the index finger of the same hand in the vagina.

3rd. While the index finger is in the vagina, the middle finger of the same hand is introduced in the rectum.

Of these three procedures the last-named is the best, for it permits us to penetrate high up in both orifices and thus explore the whole extent of the recto-vaginal septum, the posterior face of the uterus up as high as the fundus, and finally the peritoneal cul-de-sac and the large ligaments. All these parts are elastic in their normal condition, and any sensation of resistance should awaken close attention, and lead us to infer that some morbid lesion exists, the seat and nature of which must be afterwards determined.

By the double touch we are also enabled to correct any errors of diagnosis so easily committed by those unaccustomed to practicing the rectal touch. The neck of the uterus, in fact, projects considerably into the intestine, and may be mistaken for a tumor of the septum or large ligaments, an error impossible to make when the double touch is practiced.

The touch being of all methods of gynecological exploration the most important and valuable, may in certain difficult cases be aided by various other useful aids, and combined with various other manipulations, and the question may arise of combining the rectal vaginal touch with hypogastric palpation, and the double touch.

We may also resort simultaneously to the rectal touch and catheterism of the bladder—when we suspect atrophy or absence of the uterus, inversion of that organ, etc. We are likewise able, in the presence of a uterine tumor, whose point of origin

we wish to determine, to seize it with a strong pair of forceps and draw it downwards, and after placing the instrument in the hands of a skilled assistant to practice with one hand the rectal touch, while, with the other hand we apply hypogastric palpation. Other better combinations may still be imagined, and suggest themselves to the minds of the wise practitioner following his wants.—*Cincinnati Clinic and Lancet.*

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## THE CANADA MEDICAL RECORD

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## COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

The detective officer of the College sends us the following details of his work, since the meeting of the Governors in September last:—

1st. The celebrated charlatan, Antoine Racicot, 220 St. Lawrence Main Street, Montreal, was prosecuted at the last term of the court; he confessed judgment, paid the fine and costs. 2nd. Another, by the name of Thomas Ward, residing at Notre Dame du Richelieu, County of Rouville, was prosecuted at the same term; he confessed judgment, paid fine and costs and promised to retire from practice. 3rd. Another, by the name of Jean Bte. Guay, residing at St. Gervais, county of Bellechasse, has been prosecuted; he confessed judgment and promised to stop. 4th. One of our well-known charlatans, named Isidore Provincial, residing at Windsor Mills, after being prosecuted, and seeing that he would not be allowed to continue practice, has removed to the United States.

## DEATH OF DR. JOHN REDDY.

Many in Montreal were startled on the 23rd of January to learn that a cable dispatch has been received announcing the death on that day in Dublin of Dr. John Reddy of this city. Dr. Reddy had not for a year or two been feeling in vigorous health, but he still attended to his practice, one of the largest in Montreal, till last June, when he left for Europe. Since that time he has been travelling principally in Italy, and accounts received indicated that this much-needed rest was having the desired effect. Unaccountably, so far as we can learn, signs of great prostration set in, and his physician advised his return to his friends in Ireland, where he had just arrived when his death occurred. Dr. Reddy came to this city from Ireland about 1850 or 1851, and very shortly after received the appointment of House Surgeon to the Montreal General Hospital. This he relinquished in 1854, and very shortly after, a vacancy occurring on the attending staff, he was, after a severe contest, elected one of its members. He continued to fill this position up to the Spring of 1881, when he resigned, receiving the thanks of the Governors of the Hospital for his services. He was, for several years a representative fellow for the medical graduates on the Governing Board of McGill University. He was also an Ex-President of the Medico-Chirurgical Society of Montreal. Dr. Reddy took little or no part in the Medical politics of the city or Province, but devoted his entire energies to his practice, which was most extensive. As an accoucheur he had considerable of a reputation, and his practice in this special department exceeded, we believe, that of any other physician in Montreal. His manner was kindly, and there are thousands who will join with us in lamenting his death at the somewhat early age of 62 years.

## MAKING ALLEGED FRAUDULENT DOCTORS.

A suit has been begun in the Supreme Court of the state of N.Y. by the Attorney-General against the Eclectic Medical College, of New York, to procure the annulment of its charter and the dissolution of the corporation. This college was organized under an act passed by the Legislature in 1865 and amended in 1869. The Attorney-General charges that the college has violated the provisions of its charter; that it has issued its diplomas in blank;

that they have been exhibited and sold, and that persons purchasing them have had an opportunity to put their own names in the diplomas, and thereby persons utterly unqualified have procured the right to practise medicine.

The New York Post-Graduate Medical School has been so successful that on or about Feb. 1, 1884, it will move to a new building, which will enable it to give hospital advantages to its matriculates.

The new building is very large, being five stories high and having a front of 95 feet.

The new announcement gives a list of 140 physicians who were matriculates for the year ending Nov. 1, 1883.

## THE INDEX MEDICUS.

This journal, published by F. Leypolot, of New York, is one which should receive support from all who take any interest in medical literature. Indeed, its discontinuance would be a calamity to the medical world. But to live it must have support, and heretofore that support has been so limited as to preclude its being continued at the price of \$6.00 a year. The publisher has accordingly issued a circular, in which he asks old subscribers if they will be willing to continue if the subscription is either \$10 or \$12, as may be found necessary, from the extent of the subscription list. We predict that the major portion will continue, and thus place it on a satisfactory basis. It should be taken by, at least, every Medical School and Medical Society in the Dominion of Canada.

## PERSONAL.

Dr. Clarence J. Chipman (M.D. McGill College) has removed from Prescott to Ottawa.

Dr. Dion of St. Sauveur has been named Inspector of Anatomy for the District of Quebec.

Hon. Dr. Ross of St. Anne, one of the Governors of the College of Physicians and Surgeons for the District of Three Rivers, has succeeded Hon. Mr. Mousseau as Premier of the Province of Quebec. Dr. Ross is a man of much ability and combines in his nature all the good qualities possessed by the French and Scotch, from both of which nationalities he has descended.