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# The Canadian Practitioner and Review.

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## Original Communications.

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### THE ASTRAGALUS IN CONGENITAL TALIPES— EQUINO-VARUS.\*

BY CLARENCE L. STARR, M.D.,

Orthopedic Surgeon to Hospital for Sick Children; Assistant Demonstrator of Anatomy, Medical Faculty, Toronto University.

The description of the pathological anatomy of the astragalus in club-foot is presented from a study of the specimens shown, which were kindly placed at my disposal by Professor Primrose, and from notes of bones obtained during residence as interne in the Hospital for Ruptured and Crippled, New York. The excellent description of dissections of deformed feet, made by Mr. W. J. Walsham, of St. Bartholomew's, London, has also been made use of.

In the deformity of club-foot all of the bones of the foot take part, either as an alteration of the shape of the bones or as an alteration of their relation one to another. The two bones in which an alteration in shape is a prominent feature, are the astragalus and os calcis, and of these the astragalus shows the most changes. The remainder of the bones are changed in their relation one to another, but very little, if any, change in shape is noted.

On account of mal-nutrition and certain restrictions in movement, the bones generally are smaller than normal, and the astragalus shares in this decrease in size.

*The head* is usually enlarged and irregular, and the rounded articular surface which fits into the concave surface of the scaphoid, instead of being directed forward, is directed nearly inward.

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\* Read before Pathological Society.

In consequence of this the head presents two facets, one sometimes devoid of cartilage on the inner aspect of the head or side of the neck, and the second external to this on the anterior surface of the head.

The inner facet articulates with the scaphoid, while the outer, well marked in fetal astragali, more or less overgrown with ligamentous structures in older cases, presents itself as a prominence on the dorsum of the foot. These facets are separated by a distinct vertical ridge, where ligaments are not attached to the outer facet.

*The neck* is elongated and presents an abnormal inward obliquity and downward deflection. These conditions are the main obstacles to correction of varus and equinus deformity.

The length of the neck equals, in most cases, the length of the body of the bone, while in some the neck forms more than one-half the total length of the bone. Normally the length of the neck is about one-third the total length of the bone.

The obliquity has been extensively investigated by Parker and Shattuck, of London, and they have made some very interesting comparisons of the obliquity in the fetus, in adults, in talipes and in anthropoid apes.

The angle of obliquity is found by fastening a thread across the trochlear surface parallel to its internal border; and another parallel to the inner side of the neck. The angle formed by the union of these two lines is taken as the angle of obliquity.

Parker's results are as follows: Twenty specimens of adult astragali were taken promiscuously and the mean angle was found to be  $10.6^{\circ}$ , the maximum was  $26^{\circ}$ , and in three cases the angle was so small that it was impracticable to measure it.

In the fetus the mean angle was  $38^{\circ}$ , the maximum  $42^{\circ}$ , and the minimum  $35^{\circ}$ .

In equino-varus the mean angle was  $49.6^{\circ}$ , the maximum  $64^{\circ}$ , the minimum  $31^{\circ}$ .

In only one case was the angle in talipes less than the mean angle of the fetal astragalus.

	Maximum Angle.	Minimum Angle.	Mean Angle.
Adult ..	26°	0°	10.6°
Fetus ..	42°	35°	38°
Talipes..	64°	31°	41.6°

Besides the inward obliquity there is in nearly every case a downward deflection of the neck, which is increasingly great as the age of the patient advances and the foot has been walked upon.

*The internal surface* is shortened from above downwards, as compared with the normal bone, and in some instances is so much so as to make the bone wedge-shaped with the base of

the wedge directed outward. This fact is especially noted by Redard, who classes this as one of the main reasons why adduction of the foot is so hard to overcome. The observation of the writer does not correspond with this, only one or two cases showing marked thinning of the internal surface. The articular portion is narrowed and found chiefly as a narrow strip along the upper border continuous with the superior or trochlear surface. The balance of the internal surface is taken up with the attachments of the deltoid ligament. The internal surface of the normal fetal astragalus shows a similar narrow band of articular surface and it extends forward on to the side of the neck.

*The external surface* has its articular surface enlarged, on account of the forward displacement of the bone, so that it extends nearly as far backward as the posterior border. The anterior portion of this articular surface is pushed forward in front of the external malleolus and separated by a distinct vertical ridge from the posterior portion which articulates with the external malleolus. Sometimes the anterior portion of this surface is thickened so as to form a prominence or even a tubercle, and may in that event prove an obstacle to reposition of the bone, by wedging itself against the external malleolus in attempts at dorsal flexion.

*The superior surface* has its articular surface placed more posteriorly than normal. The surface commences about half-way back on the bone and extends backward from this point to the posterior surface. The anterior part of this new trochlear surface is about normal in width, but gradually tapers as it proceeds backward, so that the trochlear surface, instead of being rectangular, is more or less triangular with the apex backward. The portion of the bone in front of this which was originally part of the trochlear surface, is usually covered with ligamentous structures, the anterior ligament of the ankle being attached to it.

*The inferior surface* may have its articular facets entirely displaced, the usual arrangement being a crowding of the posterior facet forward so that it comes to occupy nearly all of the surface. The long axis of this facet, instead of being directed forward and outward, is directed forward or even in some cases slightly inward. The interosseous ligament is thinned at its posterior part or sometimes is absent. The anterior facet is small and placed partially under the sustentaculum tali and partially on under surface of the neck.

*The posterior surface* is nearly lost, only a narrow edge of bone representing this surface, separating the superior from the inferior surfaces. The groove for the tendon of the flexor longus hallucis is nearly always absent or very slightly marked when it is present.

# Clinical Notes.

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## A CASE OF TROPICAL MALARIA

REPORTED BY GEO. A. SUTHERLAND, M.D.,

Of the Resident Staff of the Toronto General Hospital.

A. P., aged 29, came into the Toronto General Hospital, under the care of Dr. W. H. B. Aikins, March 8th, 1899.

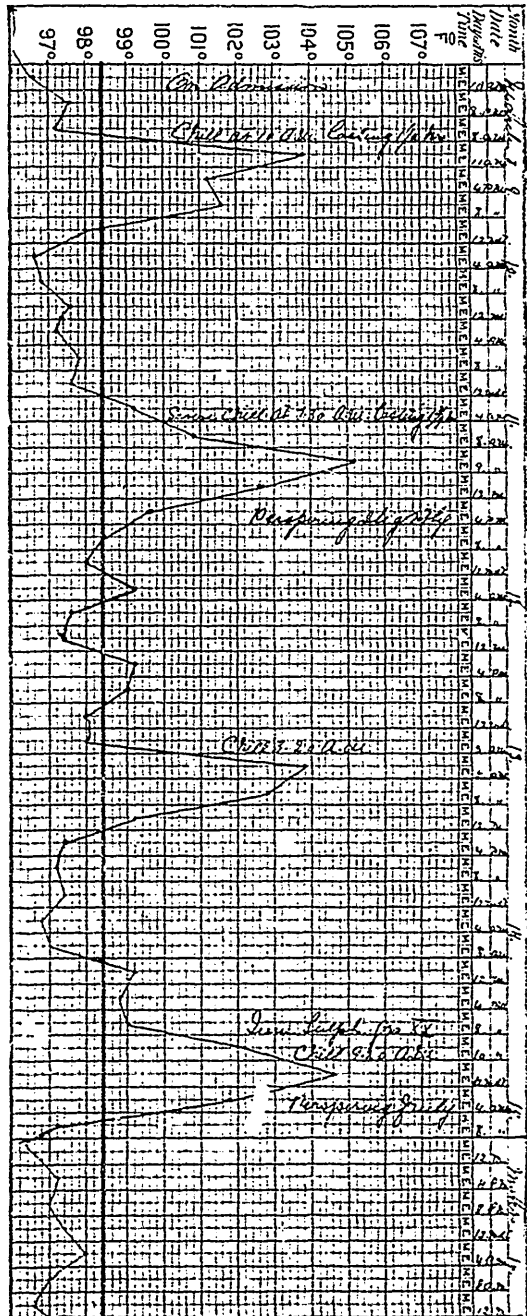
His history, briefly, is as follows: He is a cook by occupation, unmarried, never had any illness of any kind, has always been strong and healthy and taken particularly good care of himself in every respect. During his stay in Cuba, engaged in the Hispano-American war, he had a severe attack of dysentery. He states having had malaria, but gives no history of any paroxysms characteristic of that disease. He came to Canada and resumed his occupation in Toronto, October 12th, 1898. On February 19th he had a severe chill, followed by fever and sweating, intense headache, prostration, pains in his limbs, nausea, and vomiting. Such paroxysms have occurred every forty-eight hours until March 15th.

The patient knows he is going to have a chill some hours before its advent by uneasy sensation in his epigastrium and occipital headache. At the beginning of the cold stage he feels nauseated, has a desire to yawn and stretch, shivers, the surface temperature is low, and the face looks cold and blanched. The headache was very severe, and the patient usually vomited. The pulse was small, hard and rapid. Rectal temperature about 103° Fah. Duration of cold stage was about 1½ hours. The *hot stage* was ushered in by waves of heat transmitted down his back: face become flushed and expression less anxious. There was intense thirst; headache remained severe; pulse was of good volume and good tension. Temperature rose to 104° and 105°. Duration of the *hot stage* was about five hours. The sweating stage followed the hot stage, and lasted from one hour and a half to two hours, after which the patient relapsed into a sound and refreshing sleep. Periods of sweating have occurred once or twice since the chills have ceased.

*Physical Examination.*—Patient is anemic; fairly well nourished and well developed muscularly. Nothing of note was found in the respiratory, nervous nor lymphatic systems.

*Blood and Vascular System.*—There is slight arterial fibrosis. The blood showed marked rouleaux formation. The differential

count resulted in a slight diminution in the number of polymorpho-nuclear neutrophils, and a slight increase in the number of the large mononuclear forms. Blood smears showed considerable blood pigment, and the presence within and without the red blood cells of the tertian malarial organism. The plasmodia were obtained up to March 19th, three days after the last chill occurred, and after the patient had had forty grains of quinia sulphate. The red blood cells containing the plasmodium were swollen to a size one and a half times the normal size; had a faint outline, and the plasmodium occupied a small or large part of the cell, according to its age. The area not occupied is clear, having lost its haemoglobin to a great extent. The plasmodium stains faintly, and contains very dark granules, which, in the fresh specimen, are in rapid motion, a result probably of Brownian movement. Smears obtained at the beginning of the paroxysm showed the plasmodium broken up in fifteen or twenty



roundish hyaline bodies smaller than a red blood corpuscle, irregularly grouped about a central mass of blood pigment. Other forms of the tertian organism were not found, probably because smears were not taken just at the proper time.

*Genito-Urinary System.*—Kidneys not palpable. Urine was increased in quantity during the chill. Amount of urine for twenty-four hours was sixty-five ounces—urea, 437.5 grs. The urine was slightly dark in color with a specific gravity of 1030—markedly acid, and having a distinct uratic deposit. Albumen and sugar were absent.

*Spleen* was moderately large and distinctly palpable and tender. It extended forwards to a point 3 inches from the median line in front, downwards  $1\frac{1}{2}$  inches below the costal margin, and upwards as far as the upper margin of the eighth left intercostal space.

*Liver* was moderately enlarged and easily palpated—lower margin in the median line to a point midway between the tip of the ensiform cartilage and the umbilicus; in the nipple line  $2\frac{1}{2}$  inches below the costal margin; in the mid-axillary line, lower border of the ninth rib.

*Treatment.*—The chills responded very quickly to quinia sulphate; no paroxysms have occurred since it was freely given. An additional examination of the blood was made on the 19th of March by Dr. H. J. Hamilton, assistant pathologist to the hospital. This showed hæmoglobin 48 per cent., and the number of red corpuscles to the c.cm. to be 2,640,000. Pepto-Mangan (Gude) was then prescribed for this condition in teaspoonful doses four times a day, and the recovery of the patient has been rapid indeed. While taking this preparation a second examination of the blood was made on the 29th March, showing hæmoglobin 74 per cent. and red corpuscles 3,820,000. Another examination on April 7th gave hæmoglobin at 80 per cent., and red corpuscles 4,280,000. A final examination, April 20th: hæmoglobin, 90 per cent.; red blood corpuscles, 4,850,000. The case is interesting because malaria is rarely met with in this district at the present time, and the few cases seen are generally imported. The other point of interest about this particular case is the quiescent stage of the disease from the early autumn months of last year to February of the present year; also the rapid increase of the red corpuscles while taking Gude's Pepto-Mangan.

## DUCT CARCINOMA OF THE BREAST: SCHLEICH'S SOLUTION OF COCAINE USED AT OPERATION.

HERBERT A. BRUCE, M.D., F.R.C.S. (Eng.).

The patient, from whom breast\* was removed, has briefly the following story:

E. T., aged 61. No relative known to have had cancer. The affection of the breast was first noticed a year ago. Her attention was called to it by a dull aching pain, felt in the left nipple, for an hour or so one night after retiring. This pain was felt a few days later for a very short time. With the exception of these two occasions, the patient has never suffered pain. She then noticed a small lump beneath the nipple. This has gradually increased in size until the present. She has had slight discharges of a bloody character at irregular intervals during the past year. The breast gives her a stiff feeling and a sensation of weight, but no pain.

*Condition on Examination.*—Nipple slightly retracted. A dark scab, evidently formed chiefly of blood, covers part of the nipple. The skin immediately surrounding the nipple is adherent to the ma. beneath. The diseased breast is smaller than the other one. The tumor is hard and resistant to the touch, rounded in form, with a fairly well circumscribed margin. It is about four inches in diameter, and surrounds the nipple equally in all directions. On putting the pectoralis major muscle on the stretch, the growth can be moved to a slight extent in the direction of its fibres. High up in the axilla three enlarged lymphatic glands could be felt. It was diagnosed as a duct cancer. As the patient had a weak heart, and it was feared she could not stand a general anesthetic, the operation was performed with Schleich's solution of cocaine. About an ounce and one-half of the solution was injected along the line of the intended incision, and half an ounce beneath the breast. The entire breast was removed with the pectoral fascia and the costo-sternal origin of the pectoralis major muscle (as the growth was found to extend into the superficial part of the pectoralis muscle). The fat and lymphatics leading to the axilla and the glands and fat in the axilla were entirely removed. The incision was closed in the usual way with silkworm gut sutures, and a drainage tube placed in the axillary end of the incision. The patient was given an ounce of brandy in addition to the cocaine injection, and although she complained at the time, she afterwards stated that she felt no pain, but was simply frightened from the knowledge of what was going on. The drainage tube was

\* Specimen shown at the Toronto Clinical Society.



removed in twenty-four hours, and the stitches were removed in ten days, the wound having healed throughout by first intention.

Duct cancer is an exceedingly rare form of the disease. It consists in the development of malignant papillomatous nodules within the dilated ducts, and usually situated close to the nipple. These nodules are covered with columnar epithelium, and are very vascular, which accounts for the blood-stained discharge from the nipple. They grow slowly, and do not as a rule attain any great size. The nipple is usually not retracted, but in this case it was to a slight extent.

Marmaduke Shield, in his treatise on "Diseases of the Breast," recently published, says that he has examined carefully six specimens of the villous variety of duct carcinoma, and has come to the following conclusions: That the disease commences as the well-known papilloma. Into the ducts, or into cystic dilations of them, simple papillary growths project. These frequently bleed and cause a hemorrhagic discharge from the nipple. They may so increase as to fill the cavity in which they originate. In certain cases the epithelium spreads through and beyond the lining membrane of the duct as an infective growth. The papillary projections are composed of flimsy epithelium loosely held together, and generally attached to a delicate central stalk containing blood vessels.

Beck and Godlee, in reporting on a specimen of Nunn's, mention the rarity of this variety of cancer, which they pronounce to be characterized by (1) a coarse fibrous stroma; (2) large spaces lined with epithelium, and often filled with blood; (3) the projection of villous growths into these spaces; (4) a tendency to infiltrate surrounding tissues.

Thin gives an elaborate account of the histology of a case of breast carcinoma where there was a disposition to form columnar epithelium. Together with Waldeyer he believes that in these cases the morbid change in the epithelium begins in the lactiferous ducts. If very complete extirpation is carried out, permanent freedom is likely to be obtained.



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## FROM ASYLUM TO HOSPITAL.

BY ERNEST HALL, M.D., VICTORIA, B.C.

Intensely satisfactory as it may be to report convalescence after the removal of physical disease, it is insignificant to that experienced when, in addition to the physical, the mental also partakes of the regenerative process. This restoration of normal psychological action, this ministrations to minds diseased is the grandest evolution of modern medicine and the surgeon's highest ideal.

Mrs. X., aged 32, excellent family history, previous health good, one child twelve years ago. Shortly after birth of child patient developed pelvic inflammation, which became chronic. After suffering two years she obtained relief. A few months after the patient began to give evidence of mental derangement, which was attributed by some of the family connections as the result of her having given some little attention to spiritualism. As stated by her sister, a most intelligent lady, the patient soon became a mental and physical wreck. She was accordingly placed in the asylum nine years.

On December 3rd, 1898, through the kindness of Dr. Bodington, medical superintendent of New Westminster asylum, I examined her under chloroform, finding retroversion with adhesions, fixed appendages and enlarged ovaries. Operation advised.

At the operation at St. Joseph's Hospital, January 27th, 1899, following conditions were found: Adhesions of clitoris, small urethral caruncle. Right ovary presented one complete cyst size of a small peach; the left was cirrhotic, and showed smaller cyst. Delicate adhesions bound these structures down to pelvic wall.

Convalescence was normal; patient gave no trouble; the mental power slowly returned. On March 14th her sister wrote: "My sister much improved; seems perfectly rational in her conversation."

Since I have not seen this case for several weeks, I do not presume to report her as completely cured, but there is reason for the supposition that the pelvic disease and the mental condition were in some way related.

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## A CASE OF BRACHYCARDIA.

REPORTED BY DR. W. E. GRAHAM,  
Of the Resident Staff, Toronto General Hospital.

E. A., male, aged 44 years, was admitted to Toronto General Hospital on March 9th, under the care of Dr. W. H. B. Aikins, complaining of occasional attacks of weakness, dizziness, blindness and shortness of breath, and a more or less persistent pain just below the left nipple, with a pulse varying from 30 to 38 or 40 per minute.

Family history is negative—neither of his parents nor any of his brothers, sisters or children have slow heart.

Personally, he was always a strong, healthy, hard-working man, working at lumbering, using coarse food, drinking very moderately, but smoking very heavily until two months ago.

He has worn a truss for four years for a hernia caused by lifting heavy stones at that time. He has suffered from dyspepsia for about five years.

Ten weeks ago, while at work, he was suddenly seized with a "weak spell," becoming cyanosed with dyspnea, dizziness and specks before his eyes, which lasted about half an hour. He had repetitions of greater or less severity every day for a week, having some days three or four. At present, he often feels weak, but has none of the severe fainting spells. He has never been troubled with edema or any signs of failing circulation.

He is a man of the phlegmatic type. Genito-urinary and nervous system are normal. Stomach examination shows deficiency of HCl and pepsin. Respirations are usually about twenty per minute; pulse, from thirty to forty per minute, full and strong; arteries, soft and elastic; heart not enlarged; impulse, faint on account of thickness of chest wall; no thrill; a soft systolic murmur at apex, transmitted to left axilla. Systole seems longer in time, but diastole is most affected. He has also a peculiar congenital symmetrical deformity of his hands. The distal phalanges are absent from first, second and fourth fingers, and the distal and middle phalanges from the third. The ends of fingers are rounded off at these joints, and nails are absent. His father, three brothers, three sisters, and six of his children have the same deformity. Two brothers, one sister and three children have normal fingers. During his stay of about three weeks in the hospital liq. strychn. was given in doses of four minims four times daily, but this did not in any way increase the frequency of the heart's action. It was also interesting to note that during residence in hospital he developed an acute tonsillitis with a temperature of 102° F., yet the pulse-rate did not advance with elevation of temperature, and at no time did it run above forty per minute.

## Society Reports.

### TORONTO CLINICAL SOCIETY.

The fifty-third regular meeting of the above society was held in St. George's Hall, Elm Street, on Wednesday evening, the 12th inst. The President, Dr. Grasett, occupied the chair.

#### Cryptorchid.

Dr. John L. Davison read short notes of this condition, and presented the patient, a boy, aged 17, for examination by the Fellows present. He said the literature was rather meagre on the subject, with the exception of Heath's Dictionary of Surgery. In the first place, regarding the question of supernumerary testicle, that they did exist was a fact, though some authorities say that a third testicle had never been actually proven. When such cases exist, there are also other marked sexual deformities. The penis was decidedly infantile; the epididymis may be found in the scrotum, though partly developed, and the rest of the testicle represented by a small mass like a pea without any particular structure. In these cases the vas deferens may be absent; the secretion cannot reach the urethra. It may be due to delayed descent if the testicle is not found in the scrotum at birth. It sometimes comes down and makes its appearance at puberty, and then there is always a hernia. It may be a question whether the case is one of complete absence of the testicle, an anorchism, or one of cryptorchidism.

Dr. E. E. King, in discussing the case, thought it one of undeveloped testicle, and was satisfied he could feel the cord on both sides. On the right side he could make out a mass the size of a small bean. He thinks as the patient grows older the organs will develop.

Dr. Davison further stated, in cases of this kind, where the testicle is in the inguinal canal or in the abdomen, if it is pressed upon for any length of time it is very liable to take on malignant disease.

#### Dermatitis Herpetiformis.

Dr. Graham Chambers presented a patient with this condition, a woman between thirty and forty years of age. The name Dermatitis Herpetiformis, he stated, was first applied to the disease by Duhring in 1884. It is a very chronic disease,

and, in fact, almost incurable. Itchiness is very pronounced; and the lesions are always grouped, and have an herpetic appearance, being irregular in form. Occasionally you get one case with one kind of lesion, and sometimes you get all the lesions together. The disease in this case first made its appearance about fifteen years ago. Previously she had been very nervous, so marked at times that she was unable to walk without assistance. Lesions were on the scalp and on all parts of the body. The patient states the lesions are smaller at the present time than at the commencement of the disease. The lesions are frequently found in groups on the face, neck, trunk and upper extremity, and there is no tendency to symmetrical arrangement. The vesicles increase rapidly in size, but rarely become bulla. They rupture and moist mucous surfaces form, increase in size, and small vesicles form around the periphery. Pustules seldom form. The angular outline to the vesicles is similar to Herpes Zoster. When the lesions heal, erythematous patches remain, and some of these show cicatrices. Itching, burning and pricking sensations are nearly always present, and the patient frequently feels these sensations in parts unaffected by the disease. She can tell the outbreak of a new lesion by pain in the region of the liver. In answer to Dr. Pepler as to his treatment in the case, Dr. Chambers said he had only had one case before this one. That case got better, but he was not so sure that she did not suffer a relapse. A form of the disease sometimes occurs in pregnancy. As a rule the disease is not fatal, but so far as he knew very few cases have been completely cured. The treatment employed in this case has not improved the patient to any great extent. Morris speaks of antimony. Wine of antimony was being used in this case, and it was proving very beneficial. In papular eczema you will find that wine of antimony acts very beneficially. You may use any drug that will relieve the itching, but of course it would be only palliative. Locally in this case he had used 2 per cent. sulphur ointment. The disease is undoubtedly a neurosis, and the treatment should be constitutional.

Dr. Chambers also presented two patients with favus, in one of whom the disease had existed for eight years, and in the other three. The mousey odor was not very well marked in either case.

### Multiple Angioma.

Dr. H. B. Anderson presented a boy with this condition, aged 15 years. In regard to family history, his mother had a few moles on her face, and his grandmother had warts about her neck and face. The patient is strong and robust, with a heavy facial expression and brownish birthmarks on the head

and nose, not raised. At about nine months a small tumor appeared in the right lumbar region, and has gradually enlarged; and other small tumors on different parts of the body. About six years ago brownish mottling of the skin appeared, and also on the chest. At times they become red. The surface of the larger ones is covered with fine hair; one on the shoulder has an uneven surface, easily indented. All have wide bases; and there are many nodules felt, invisible to the eye. The left breast is diffusely enlarged; the lower ribs prominent and bulged outwards, and a deep depression is seen in the lower sternal region. The condition appears to correspond more to molluscum fibrosum, with brownish pigment moles and enlarged subcutaneous glands, some of them being vascular enough to suggest an angiomatous condition. Microscopically Dr. Anderson thinks the tumors would show fibrous tissues with dilated blood spaces. Some authorities say they really rise in the connective tissue of the nerve sheaths. That is the view generally held at the present time. In some cases there have been as many as three or four thousand, covering all parts of the body. Others classify these under fibrous tumors, but Senn says they are infective. They are as a rule congenital, being present at birth, but continue to grow afterwards for a considerable length of time. As to prognosis, they undergo involution in some cases. Most frequently after attaining a certain size the tumors become stationary. In some cases they may take on a sarcomatous condition and grow very rapidly. Defective mental development is usually found present, and there is also a tendency to deformities in different parts of the body. Dr. Anderson thought the neurotic origin was shown.

#### Vesical Calculi.

Dr. Grasett exhibited two vesical calculi, one of which was of a peculiar elongated shape, slightly curved and about two inches in length. The first was from a man of twenty-five or thirty years. There was no previous history of any renal attacks. The patient stated that last spring, without any of the ordinary causes that might produce cystitis, he was attacked with that disease. When first seen by Dr. Grasett he had an acute exacerbation with temperature elevated to 102 degrees. After the subsidence of the fever he was sounded and a stone immediately found without any difficulty. His physician in Japan had never sounded, although he had been under his care in the hospital there for some time. In the patient who had the stone of peculiar shape, prostatic abscess had been at first diagnosed. Dr. Grasett stated he had tried lithotrity in this case, but could not crush on account of not

being able to get the stone into the instrument. He described further how the stone had been removed by the lateral operation. It was partially encysted, and occurred in a young man of some seventeen years.

### Double Amputation of both Arms at the Elbow-Joint.

Dr. George A. Peters showed three specimens in which injuries of the forearms and hands necessitated amputation at the elbow-joint. Two of the specimens were from one patient, a young man nineteen years of age, the result of a railway injury, in which both arms were crushed by the wheels. The right arm was removed soon after the injury. The patient begged very strongly to have the other saved, and the surgeon promised not to do an amputation that night until his friends arrived. The right arm shows double fracture of the radius and ulna, the ulna being comminuted. The radius was broken about the junction of the lower and middle third of the bone. The epiphysis is completely separated from the shaft; and there is also compound dislocation at the wrist-joint. In regard to the right arm the skin was torn very badly. The surgeon was able in this case to amputate below the elbow, near to the joint, and get a very good flap of skin, and it healed by first intention. On the other arm the fracture was evidently not nearly so severe. The only injuries to the skin were two openings. The point he wished to make with regard to the degree of injury to the skin, is this, that in the left arm where the injury to the skin was less than in the other, the skin had been torn away from the muscles to a much higher level. The skin was dragged away from the muscles beneath, and was separated to a point above the elbow. In this arm he could not amputate below the elbow-joint. He tried first, but found he had to remove it at the elbow-joint. Even after that a portion of the skin sloughed and has since healed by granulation, so that he has a fairly good stump on that side now. The rule in regard to the amputation of such cases has been very forcibly exaggerated by Mr. Cheyne, of Edinburgh. He says that in these cases of crush from heavy machinery, the rule should be to amputate above the part that you think will recover. The circulation in the left arm was excellent, with all the degree of fracture and tearing of the muscles, tendons, etc., and the nerves were intact, and the patient could feel all over that hand. There was no coldness, and you could feel the pulse at the wrist; and yet under anaesthesia the surgeon found that the skin was entirely separated and there was a great degree of laceration of the muscles. Is the circulation all right? Can the hand survive? Are the nerves all right? In both these were present. It is quite possible the hand might

have lived, but it would have been useless. The hand would have been stiff and a club on the end of his arm, and would have been useless. Another thing, during the process of recovery provided an attempt was made to save the arm, one runs a great danger of sepsis and risk to life. The left arm Dr. Peters amputated the next morning after the condition was found after anaesthesia.

The other case exhibited by Dr. Peters was the removal of the arm below the elbow-joint in an electrical machine. Thinking the current was turned off, the electrician had passed his hand into the box or cylinder to perform some adjustment, when the piston came down and cut his arm off cleanly. It was as evenly cut around as the end of a cuff. The skin had retracted some when seen by the surgeon. In this case, Dr. Peters amputated high up and just saved the elbow-joint. He first stitched the skin over the end of the stump in several directions, and then proceeded to do a circular amputation and in that way he was able to go close to the elbow-joint.

In regard to efforts to save the elbow-joint, it is important to save the attachments of the muscles which pass down from the arm to the forearm, viz., the triceps, biceps, anconeus and brachialis anticus.

#### **Injury of the Forearm.**

Dr. Nevitt showed a patient, a man about forty-five to fifty years of age, who had sustained an injury to the forearm with a considerable degree of laceration, and yet with good circulation through the vessels in the hand. The injury was a machine accident, and consisted of a compound dislocation at the elbow-joint and a double or a multiple compound fracture of both bones of the forearm. At first sight nobody would have said a word but that the arm must come off. When the elbow was reduced it looked very presentable, and finding the circulation good, Dr. Nevitt determined to try to save it. The injury to the bones of the arm was very considerable, and the injury to the muscles. Exactly what the injury was, he was not prepared to say. The patient was here presented to the Fellows, and Dr. Nevitt said the condition of the hand and arm is there to show for itself, and the question is whether that is as good as an artificial arm.

Dr. Bruce, who had charge of the case during the illness of Dr. Nevitt, supplementing the data already given, said, four weeks after this accident was received Dr. Nevitt had asked him to look after the case. At that time there was a sequestrum found, although it was present at the time of the accident. This sequestrum was about  $1\frac{3}{4}$  inches in length, and was pressing between the ends of the bones. The upper fragment of the



ulna was bent over towards the lower fragment of the radius, and if united in that way there would be no movement in the arm; everything would unite in a mass. Dr. Bruce took a small section out of the radius and wired the bones into position, so that the two fragments of the radius would be in contact with each other—and the fracture was oblique. At the time of making the incision, a mass almost the size of one's fist issued out through the incision, and this seemed to be pulplified muscle, with some old organized blood clot. When that occurred, the anterior surface of the radius appeared. At least three-quarters of the flexor muscles of the forearm were entirely destroyed. There were no muscles to act upon the tendons lower down. The tendons could be seen at the lower part with no muscles attached above. The sequestrum was a piece of bone broken off at the accident, and not a piece which had sloughed off.

Drs. Wm. Oldright, E. E. King, A. Primrose, President Grasett, A. A. Macdonald, Thos. Millman and Geo. A. Bingham participated in a very animated and interesting discussion of the cases.

Replying to the criticisms, Dr. Peters said, in reference to the left arm, no one would deny that the skin would slough. The bones are gone, and all the extensor tendons are gone. Some of the flexors are left. The tendons are there, but the muscles are crushed, while the veins remain patent throughout through the sloughing area; and in the meantime the man's life is in danger every moment. The mortality is much greater where amputation is not performed. Dr. Peters had no doubt in his own mind that the hand would have become gangrenous in the course of a few days, although the circulation was so good at the time. When swelling occurred, the inflammatory exudate would have choked the veins, and in a very short space of time the arm would have been gangrenous.

The discussion was adjourned until the next meeting in May.

*Nomination of Officers for 1899-1900.*—President, Dr. Geo. A. Bingham; Vice-President, Dr. W. H. B. Aikins; Corresponding Secretary, Dr. G. Boyd; Recording Secretary, Dr. George Elliott; Treasurer, Dr. W. H. Pepler. Executive Committee (five to be elected): Drs. H. B. Anderson, George A. Peters, E. E. King, H. A. Bruce, G. Silverthorn, J. T. Fotheringham, A. Primrose, A. A. Macdonald, W. B. Thistle, B. Spencer, and Geo. W. Badgerow.

GEORGE ELLIOTT,

*Recording Secretary.*

## TORONTO PATHOLOGICAL SOCIETY.

The usual monthly meeting of the Toronto Pathological Society was held in the Biological Building, Queen's Park, on March 25th, Dr. Primrose, President, in the chair. Present: Drs. Rudolf, Silverthorn, W. J. Wilson, F. N. G. Starr, J. J. Mackenzie, H. B. Anderson, Parsons, Carveth, C. L. Starr, Hamilton, McPhedran, Wm. Oldright, Fotheringham. Visitors: Drs. Page and Sutherland.

Minutes of last meeting taken as read, and adopted.

Dr. C. L. Starr was elected member of the Society.

Dr. F. N. G. Starr presented the following communication :

### The Eustrongylus Gigas from the Kidney of the Mink.

During a recent hunting expedition, my friend, Dr. J. M. McCallum, among other things shot a mink. Having skinned the beast some three days after death, he handed the carcase over to me. I found the animal to be plump and well-nourished, with plenty of adipose tissue. Upon palpating the abdomen the left kidney seemed to me to be larger than necessary for an animal of the size ; hence I cut down upon it, but found it normal in appearance and of a large size. It measures 4 cm. At first I was unable to locate the other kidney, but finally decided that a large membranous sac-like structure, bluish in color, occupying the right renal region and lying in contact with the under surface of the liver, was all that was left of the kidney. It measures 6.5 cm. Upon section, a bloody sero-gelatinous material escaped. The wall of the sac was very thin, resembling a thickened capsule, and on its inner aspect what appeared to be remains of kidney substance could be made out. In the sac were numerous coils of the eustrongylus gigas, and one could observe a slight vermicular motion. There are at least two worms, for I have been able to demonstrate three extremities without interfering with the natural arrangement of the specimen. The worms are of a brownish-red color, very much like the color of fish-worms from a manure heap. You will also observe among the coils of worms a long bone-like structure, which presents numerous rib-like processes. Originally this structure probably occupied the pelvis of the kidney, these processes extending into the calices, and it would seem that these rib-like extremities extended at one time into the mouths of the papillæ.

Davaine says that the worm is found in the dog, the marten, the otter, the mink, and other fish-eating animals. It is most frequently found in Holland and in France, more having been reported from Paris than elsewhere. It must, however, be comparatively rare, for in an examination of three

thousand human subjects and of five hundred dogs it was never found. The ordinary abode seems to be somewhere along the genito-urinary tract, usually within the pelvis of the kidney or the calices, rarely in the bladder or ureter. If not in the genito-urinary tract, it is found somewhere close to it, having made its way out into the adjacent structures. Rarely are there more than two worms, usually only one, but as many as eight have been discovered. The substance of the kidney is, as a rule, destroyed. If the animal has been under observation for some time, frequent hemorrhages will be observed. The kidney will appear as a large membranous sac, and when opened a varying quantity of sanguinolent material will escape; sometimes there will be pus, when the worm, instead of appearing of a brownish-red color, will be of a dirty white. The capsule of the kidney spreads out and becomes discolored, undergoing changes which so far have not been much studied. In the pelvis a bone-like structure has been mentioned a number of times.

Leuckart describes this hardened mass as a "calcification, bone-like in appearance." Weinland, in speaking of the kidney in a case of this kind, says that there was nothing left but the "outer skin," forming a regular worm sac; while inside, besides six worms, there was a thin bone-like structure. So far as I have been able to learn, no one has, as yet, subjected this "bone-like" structure to the microscope. From my specimen, Dr. R. R. Bensley, Lecturer on Histology in the University of Toronto, took a portion which he decalcified and cut into sections. Under the microscope you will observe that it is not only "bone-like," but it is really true bone. The question naturally arises as to the origin of this bone. Of course, it is possible for bone to develop from connective tissue, as, for example, in the ossification of the tendons in a turkey's leg, and in the sesamoid bones of the human foot, or in the adductor muscles, giving rise to the "rider's bone." Bony growths, too, have been described as occurring in the testicle and kidney. In this kidney where did the osteoblasts spring from? Upon some future occasion, Dr. Bensley and I hope to make a communication to this society on the subject, for at present our investigations have not gone far enough to warrant us in expressing an opinion. Dr. Bensley also sectioned the sac-wall, and could discover no kidney substance whatever.

Stratton, of Kingston, Canada, reported a specimen of this worm found in the peritoneum of a dog. There were four living worms discovered, though the dog had been drowned through the ice several days previously. He hunted for, but failed to discover a perforation of the bowel, believing them at first to be the ordinary round worm.

Irving H. Cameron, of Toronto, has told me of a specimen in the kidney of a dog, shown to the class in physiology by the late Michael Barrett. This specimen is now in the Pathologic Museum of the University of Toronto.

Erasmus Miller, of Dorchester, U.S.A., reports finding a specimen in the kidney of a fish-eating marten.

Theo. Kerchering mentions the case of a dog where the whole length of the ureter was occupied by a worm. The animal was ill nourished, and was killed because of its constant howling.

Le Blanc describes a case of tumor in a dog near the penis, from which upon opening he removed a specimen of the *eustrongylus gigas*. He thought it had probably passed from the kidney to the bladder, and thence to the urethra. Upon reaching the canal in the bone of the penis it was unable to pass further, and then made its way into the periurethral tissue.

Van Sweiten mentions finding a specimen of the *eustrongylus* in the kidney of a dog that had suffered from pain, hematuria, and difficulty in urination.

There are a number of cases reported as having occurred in man, but Leuckart believes them to have been cases of the *ascaris lumbricoides*. If the condition should occur in man, and the worm remain in the kidney, there may or may not be any symptoms. If, however, one should pass along the ureter, the symptoms would be those of renal colic. One could arrive at a diagnosis, however, by finding the eggs in the urine. These are very numerous, and are  $\frac{8}{10}$  m.m. long by  $\frac{1}{10}$  mm. wide.

In the Cobbold Catalogue of Entozoa, in the Royal College of Surgeons of England, a specimen of the *eustrongylus* is mentioned. In describing it, Brooks says: "This fine female specimen (18 inches long) was found in the kidney of a patient of the late Thomas Sheldon." Maublet reports the case of a boy five years old, from whose bladder he removed a calculus. Four years later the boy suffered from anuria, with pain and swelling in the lumbar region. The urine became thick. At the end of fourteen days pus made its appearance in the right lumbar region. This was evacuated, and the wound continued to discharge for two months, when it cicatrized. Soon the region became inflamed and was re-opened. When dressing it the following day, the mother removed a large worm on the dressings, and Maublet found a smaller one. Two days later the child could not pass urine, and an attempt to pass a sound failed. The boy was put in a hot bath, when a worm made its exit from the urethra, and on the following day another passed. In one month the lumbar wound was entirely healed. At the end of five years the

patient was reported to be in good health. Duchateau reports the case of a soldier who suffered from attacks of pain and hematuria every other day for five days, when he passed half a chamber pot of blood clot and bloody urine. In the chamber was found a living worm, brownish-red in color; it measured one line in diameter, and was four inches long. The patient had lived in Holland. Aubinais related the case of a farmer aged 60, who was robust and in good health. He began to suffer from pain in the right lumbar region, from which he got no relief. In three years his obesity was reduced, and movements could be made out in the lumbar region. He finally died of marasmus, after which the flank was incised and the kidney removed. In it movements could be distinctly made out twenty hours after death. A worm 43 cm. in length was found upon opening the kidney.

Dr. Starr also presented a number of specimens prepared according to the method of Toré, and showed methods of preparation by means of formaline injection. Discussion by Drs. Anderson and Mackenzie.

Mr. J. J. Mackenzie made a further communication on the "Timothy Hay Bacillus," to be published later.

#### **Pyo-pneumo-thorax.**

Dr. McPhedran: W. M., aged 22, entered Toronto General Hospital March 7th, 1899; complained of cough, expectoration, difficult breathing. Family history unimportant. Personal history: Painter and general laborer for two years. No illness except "inflammation of the lungs" when twelve years of age, after which he caught cold very easily when exposed. Passed medical examination at London Military School two years ago. Five months ago had a sudden hemorrhage, supposed to be from lungs, and taken to St. Michael's Hospital and treated for phthisis. Remained there two weeks. While there developed a cough, which remained steadily ever after. Was not able to work when he left St. Michael's, and steadily lost strength and weight. About two weeks previous to admission to Toronto General Hospital he was exposed to a cold wind, and his cough became much worse. For several days previous to admission he complained of a dull pain in the left side in infra-clavicular and axillary regions. This pain had ceased when he was admitted.

*Condition on Admission.*—Temperature 101.8; pulse 130; respiration 36. Complained as before mentioned; in bed, lying on left side; face, neck and arms cyanotic, expression anxious; alae, nasi expand with each inspiration; lips pale, dry and cracked, with an eruption on lower lip. Thorax: No expansile movement of left side; left intercostal spaces bulging

except supra and infra clavicular spaces, which were retracted. Left side: Heart impulse not seen on left side, but extended out to mammary line on right side; right side expanded freely; diminished vocal fremitus and vocal resonance on left side; increased on right side. Breath sounds: Distant tubular breathing on left side; bronchial breathing with moist and crepitant rales on right side; succussion sound on left side, when moved; percussion note tympanitic at first on left side but became much higher in pitch and muffled afterwards; metallic echo over left chest when percussed with coins. Percussion note of right side: No areas of absolute dulness but some areas of relative dulness; heart sounds weak, pulmonary second sound accentuated. Abdomen: Liver three fingers below costal margin in right mammary line; spleen palpable; sputum examined frequently for tubercle bacilli, but none found; no pneumococci found; sputum muco-purulent. Examination of urine when admitted. Clear light yellow; acid; 1020; no sugar, no albumen, no sediment. Left chest tapped Tuesday, March 14th; escape of air and 1,000 c.c. of a greenish-colored sero-purulent fluid of specific gravity 1030; cultures from fluid resulted in pure growth of streptococcus pyogenes.

*Post-mortem Examination.*—*Rigor mortis* marked; *post-mortem* staining in dependent parts; orifices normal. Measurements: Left chest, 18 inches; right chest, 16 $\frac{3}{4}$  inches; intercostal spaces on left side obliterated; herpes, right lower lip. Section: Fat almost absent; muscle thin, dark, red; the diastinal pleura adherent to sternum. Peritoneum: 10 ounces clear serous fluid in pelvis. Pleuræ: Left pleural cavity contains air; cavity projects over to right border of sternum; old adhesions at apex of left lung posteriorly and externally; these adhesions very strong and extend from vertebræ to post axillary line; left pleura much thickened. Right pleura: No adhesions; has lost its glossy appearance; ragged in parts and some recent lymph exudate. Lungs: Left—adherent apex and posteriorly; collapsed; small irregularly round aperture in posterior part of upper lobe 2 $\frac{1}{2}$  inches from lower margin; this opening communicated with a small cavity beneath pleura which again communicated with a large cavity; Right—28 ounces; some emphysema of anterior margin; diffuse miliary tuberculosis; some areas of broncho-pneumonia; no cavities; mucous membrane congested and slight dilatation of bronchi. Heart: Displaced to right side; apex behind sternum; right border behind right nipple; weight 10 $\frac{1}{2}$  ounces; cavities contained a.m. and p.m. clots: right ventricle distended; some hypertrophy and dilatation of right ventricle; muscle soft and flabby; valves normal; endocardium normal; pericardium contains 6 ounces of slightly fibrinous turbid fluid; visceral pericardium

over right auricle presented a few small tubercle. Spleen : Enlarged ; 6 ounces. Kidneys : Showed congestion and cloudy swelling. Liver : 65 ounces ; cloudy swelling and fatty degeneration ; edge  $1\frac{1}{2}$  inches below c.m. in right mammary line. Small intestine : Tuberculous ulcers in lower part ; small and large intestine distended with gas.

Dr. Rudolf, in discussing Dr. McPhedran's paper, said in this case there were signs of high positive pressure, *i.e.*, heart much displaced, intercostal spaces puffed out and almost a dull note on percussion. This positive pressure must have been produced by a valvular opening. It probably caused the great stretching of some old adhesions so that they have become cords.

### **Astragalus in Congenital Talipes—Equino-Varus.**

Dr. Clarence L. Starr presented a paper on the above subject. (See page 255.)

### **Cerebral Hemorrhage.**

Dr. H. J. Hamilton showed the brain from a case of cerebral hemorrhage with crossed paralysis.

J. M., aged 54, came into the Toronto General Hospital December 29th, with a history of having an apoplectic stroke the same day. She was unconscious from the moment the paralysis set in and remained so until her death, which took place December 31st, 1898, at 5 p.m. From her friends it was gathered that she was a hard-working, temperate woman, and that the attack was sudden, the patient almost falling on the stove. There wasn't a single premonitory symptom. Upon examination complete motor paralysis of the left lower half of the face and the whole of the right half of the body with the exception of the face, was found. There was a dulling of sensation with increase of deep reflexes in the paralyzed parts. Pupils equally normal, reacting to light and distance. Patient had retention of urine, catheterization being necessary every six hours. The bowels didn't move whilst in the hospital ; there was slight arterio fibrosis ; heart was slightly enlarged ; urine normal, and the patient was otherwise perfectly healthy.

*Autopsy.*—On *post-mortem* examination the body was observed to be well nourished, *rigor mortis* well marked ; heart weighed 9 ounces ; coronaries rigid and arterio-sclerosis marked ; the right ventricle full ; the lungs are both engorged and weighed 15 ounces each ; spleen small,  $2\frac{1}{2}$  ounces. Kidneys : Left weighed 2 ounces, right 3 ounces ; capsules adherent and cortex cirrhotic. Brain and membranes : Weight,  $38\frac{1}{2}$  ounces ; the left lateral ventricle was full of a semi-fluid clot ; engorged vessels over the left cerebrum very marked, less so on the right ; a great deal of blood welled up through the curved sulci

on the under surface of the left hemisphere of the cerebellum, the tissue of which was somewhat broken down. The other organs of the body were normal in appearance.

Drs. Anderson, Primrose, Parsons and others discussed the case, and the conclusion was that there had been a small hemorrhage in the pons, causing the crossed paralysis, and that death ensued at once after the free hemorrhage into the ventricle.

Dr. Anderson showed enlarged spleen of doubtful origin, with notes. To be published later.

Dr. Primrose showed a heart with advanced calcareous changes in the coronary arteries.

H. C. PARSONS, *Rec. Sec.*

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SUIT FOR MALPRACTICE AND JUDGMENT FOR TWO THOUSAND DOLLARS.—On Wednesday morning it was published in the New York daily newspapers that an action had been closed against Dr. Thomas H. Manley, and judgment ordered in the sum of two thousand dollars, no defence being offered. It appears that a woman had brought an action against Dr. Manley, alleging malpractice in the surgical treatment of a disease of the thumb. As Dr. Manley had received no notice of the trial or date for a hearing judgment was given before a sheriff's jury in the amount claimed. Immediately after a motion was made for reopening the case, which was granted. This case is peculiarly interesting as the woman was a charity patient treated in a public institution.—*Boston Med. and Surg. Jour.*

THE PRACTICE OF MEDICINE IN ITS PROPER LIGHT.—We quote the following from the *Clinical Reporter* for February: "What are we practising medicine for? Is our profession a business or a pastime?" These are questions put by *The Medical Examiner* in an editorial that appears in its current issue in defence of commercialism in medicine. "Is our profession a business or a pastime?" Neither, essentially, my Lord! Our profession is "first, last, and all the time, a profession. Incidentally it may, in rare cases, be a pastime; it is, in most instances, a means of making a livelihood, and so far, incidentally, a business; but the relations which it establishes are relations of a peculiar personal trust on the part of the patient, not only in the skill but also in the personal honor of the physician. It is this element of personal trust which, above all, distinguishes a profession from a mere business, and which forbids all devious methods, all commercial systems of offering or receiving commissions from other professional men, specialists, etc., for cases referred. It will be a sorry day for the medical profession when the majority of its members will look upon it as primarily a business—a sorer day for their patients!—*N. Y. Med. Jour.*



# Editorials.

## PLACARDING HOUSES.

The subject matter of a communication from a Toronto physician, "Sydenham," which appears in this issue, is in many respects important. On the one hand, it is a very serious matter for a family to have their house placarded in a way to indicate that diphtheria or scarlatina exists in it: on the other hand, it is equally serious, in some respects much more so, not to adopt effective methods to prevent the spread of these diseases. This will generally be accepted as a truism, but there is a great difference of opinion as to what is the best practicable method in the interests of the public.

Isolation is never thorough and never can be without taking and caring for the patient in a special hospital. There must necessarily, therefore, be some elasticity of rules or methods prescribed by the health authorities. Bread-winners in a family are generally placed under certain restrictions, but, notwithstanding the presence of infectious diseases in their homes, are allowed to mix with the outside world. The baker, the butcher, and the milkman, deliver food to the inmates of the infected houses. Under any system of inspection these privileges are sources of danger. Our medical health officers very properly endeavor to prevent and direct communication of the patient with the outer world.

Does the ugly-looking card decrease the danger of conveying infection? A large number of physicians in Toronto say, decidedly, No. It is frequently difficult to make a differential diagnosis between scarlatina and roseola, "tooth rash," "heat rash," or various forms of erythema; also between diphtheria and follicular tonsillitis, especially when no great effort is made to do so. The majority of householders have a very decided objection to the "hideous-looking thing;"—the placard—and will feel very grateful to the doctor who says, "This is a case of ulcerated sore throat; but, to be on the safe side, we will just keep Jimmie in a room by himself for a few days;" or, "I'm

not quite sure about this; it looks like a heat rash or a rose rash, but I think we had better keep him from the other children for a few days; it will probably not be necessary to report the case. Some householders, we understand, refrain as long as possible from calling in a physician for sore throat or scarlet rash on account of their dread of the card.

We would be very glad to receive and publish other communications from physicians who hold rather strong views on the subject, as we happen to know. At the same time it should be understood, we think, that the provincial and local health authorities have no desire to enact or enforce any laws that are unnecessarily vexatious to the profession and the public.

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### THE ONTARIO MEDICAL ASSOCIATION.

The next meeting of the Ontario Medical Association will be held in Toronto, June 13th and 14th. The President, Dr. W. J. Gibson, of Belleville, has had several conferences with the different committees, especially the Committee on Papers and Business. We learn from the Secretary that the latter committee, under the chairmanship of Dr. Jas. F. W. Ross, have nearly completed the programme, or at least the frame-work of the programme.

Certain subjects of especial interest to the medical world will be discussed at considerable length. Among these one of the most important will be "The Sanitarian Treatment of Tuberculosis." Dr. Vincent Bondich, of Boston, who has paid a great deal of attention to the subject, will open this discussion. Dr. Wilson, of Boston, has promised to present a paper on "Perforation in Typhoid Fever," which, it is confidently hoped, will elicit an extended discussion. It is also expected that Dr. Fenger, of Chicago, will open the discussion on "Surgery." Several members in various parts of Ontario have also promised papers.

The Committee of Arrangements, under the chairmanship of Dr. J. Algernon Temple, has also done some work. It is expected that a banquet will be held on the first evening of the meeting, in accordance with some by-law passed last year to the effect that there shall hereafter be an annual banquet attended

by the members, for which each shall purchase his own ticket. We regret that such a law was enacted, as the custom which formerly prevailed, viz., the entertainment of the visitors at a light luncheon by the members resident in Toronto, was generally satisfactory.

We are requested to state that it is desired that the members throughout the Province intending to present papers will forward the titles of the same to the Secretary, Dr. Harry C. Parsons, 97 Bloor Street West, Toronto, as soon as possible.

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### SANITATION IN SANTIAGO DE CUBA.

From a humanitarian point of view, America's war against Spain will be productive of much good to Cuba. The *Buffalo Medical Journal*, April, 1899, publishes an interesting article on the changes brought about in Santiago, chiefly through the energy and ability of Dr. Leonard Wood, who, when the war began, was an assistant surgeon, but in a very short time became a general officer. After the surrender of Santiago, Major-General Wood was appointed Military Governor of the Province of Santiago de Cuba, July 20th, 1898. At that time Santiago, we are told, was probably the filthiest city in the world. Its inhabitants were sick, starving, and two hundred of its people were dying every day. The difficulties in the way of bringing order and cleanliness out of chaos and filth were enormous. In the article referred to we find the following: "A physician who was a sanitarian, a soldier who was a disciplinarian, and a statesman who was a financier and a diplomat—all these were needed in the person who should attempt to administer the affairs of Cuba."

After four months of General Woods' administration we find, from Mr. Lewis's article in *McClure's Magazine* for March, that the following changes, with others, were effected: The population were rescued from starvation to a fair satisfaction of all their daily necessities. One of the foulest cities on earth was converted into one of the cleanest. The daily death rate was reduced from two hundred to ten. Radical reforms in many other directions were effected.

The article concludes as follows: "This unparalleled regenera-

tion had been wrought, not by a host of men native to the locality, exercising offices long established and enjoying a traditional prestige, but by an American brigadier-general of volunteers, a stranger to the place and the people, embarked in the work on a moment's notice, and having for his immediate aides only a few fellow army officers, some of whom had been out of West Point less than two years, and all of whom were as new to the situation as himself. It was the *tour de force* of a man of genius; for in the harder, more fundamental, of the tasks that confronted him here, General Leonard Wood had no previous experience." General Wood is only thirty-eight years old.

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### THE MEDICAL PROFESSION AND THE UNITED STATES GOVERNMENT.

We find an able and interesting editorial on this subject in the April number of the *American Gynecological and Obstetrical Journal*. The writer considers that the position of the medical profession of the United States in relation to the Government is anomalous. Although there is a Surgeon-General in the army he is simply a member of the Adjutant-General's department, bearing a great responsibility without authority to act excepting under the orders of the Secretary of War as expressed by his Chief of Staff. The unhappy condition of the troops in Cuba, and on the transports in the late war, furnishes ample evidence of the ineffective condition of the Medical Department of the army.

It is contended that the profession has corporate needs as well as corporal ones, and should be represented in the highest councils of the nation; or, in other words, the Surgeon-General, as the representative of the profession, should be a member of the Cabinet, and his appointment or election to this position should not depend upon political patronage, but rather on the recommendation of the profession of the country through its State medical societies or otherwise.

We quite agree with the opinions expressed in this article. Matters pertaining to public health, both in time of peace and of war, ought not to be under the authority and supervision of

any layman. The head of a department of public health ought, of course, to be a physician, but he ought not to be under the control of an Adjutant-General or a Minister of Agriculture. We think that in our own country our able head of this department should be a member of the Government, and should assume full responsibility for all laws governing health matters. We will watch the results of the endeavors of physicians in the United States to obtain such a condition of things in their country with considerable interest, but without any great hope for a radical change in the near future.

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### MEDICAL ITEMS.

Robert Muir, M.A., M.D. (Edin.) has been appointed Professor of Pathology in Glasgow University in the place of the late Professor Coats.

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THE CHAIR OF OTOLOGY IN VIENNA.—The two chairs in otology at the University of Vienna, formerly held by Professors Gruber and Politzer, have been united into one, with Professor Politzer as incumbent, Professor Gruber having retired.

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W. M. Hicks, known to some as Dr. Hicks, was fined \$25 and costs in the police court, Toronto, for practising medicine without a license. His method of treatment was to rub the patient's body, for which he charged, and to give gratis a quantity of tablets which were to be taken internally. The magistrate held that the benevolent part of Hicks' practice was simply a scheme to circumvent the law.

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A CORRECTION.—I have received from the master of the Rotunda a slight correction of our paper on obstetric methods in use there. Their treatment of placenta prævia is to do bipolar version, and bring down a leg, and the cases in which it is necessary to plug the vagina first, are very exceptional indeed. In my paper not sufficient emphasis was placed on the rarity of these cases, making their main line of treatment seem secondary to that, which is only applicable to a very small percentage of cases.—K. C. M.

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TRINITY MEDICAL ALUMNI ASSOCIATION.—The annual meeting of the above association will be held in the theatre of the Normal School building, Toronto, on Wednesday, May 31st,

1899. The programme of the meeting will include the names of men well known to the profession from the United States as well as from our own province. The annual banquet will be held in the evening, at which the gold medal offered by the association for the thesis of most distinguished merit, written by a graduate of Trinity and read at the general meeting, will be presented to the winner. The General Secretary is Dr. George Elliott, 129 John Street, Toronto.

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CANADIAN MEDICAL ASSOCIATION.—On August 30th, 31st, and September 1st, 1899, the next annual meeting of the Canadian Medical Association will be held at Toronto, under the presidency of Mr. Irving H. Cameron. It is now some ten years since this association met in Toronto, and every effort will be put forward to make this the most successful meeting ever held. One of the most interesting features of the meeting will be the probable arrangement of the final details of a scheme whereby Dominion registration will become, in the near future, an accomplished fact. This, together with an ever growing interest in the value of the association as a promoter of scientific research, will add materially to the success of the Toronto gathering.—F. N. G. STARR, Secretary.

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NEWSPAPER ADVERTISING.—We have received a communication referring to an advertisement, which recently appeared in the *Toronto Mail and Empire*, containing the opinions of certain physicians of this city about the recent influenza epidemic, together with a statement that “eminent physicians endorse and recommend ——— nerve food.” The facts are as follows: A *Globe* reporter interviewed certain physicians, and published the results, without having reference to any patent medicine. The proprietors of a certain nostrum copied some extracts from the *Globe*, and mixed them with certain laudatory remarks about their specific *grippe* cure in a somewhat cunning way. Some of the physicians concerned, probably all, felt greatly chagrined and mortified, and took steps to have their names removed from the advertisement. As the matter may be brought up in the courts we will not further discuss it. We simply offer this explanation of an extraordinary (to put it mildly) use of the names and opinions of reputable physicians.

# Progress of Medical Science.

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## MEDICINE.

IN CHARGE OF W. H. B. ATKINS, J. E. GRAHAM, J. FERGUSON, T. McMAHON,  
H. J. HAMILTON, AND INGERSOLL OLMSTED.

### Granular Kidney.

Dr. Samuel West, in the Lettsomian Lectures (*Brit. Med. Jour.*, Feb. 11, 25, and March 11), enters into a very thorough clinical study of granular kidney. One of the first things to which attention is called is the fact that granular kidney is often found *post-mortem*, when it was not suspected during life. The general *post-mortem* frequency ranges from eleven to eighteen per cent. The tendency is for the disease to become steadily more frequent with increase of age.

Granular contracted kidneys are of two kinds: the small white and the small red kidney: or white cirrhotic and red cirrhotic. It must be borne in mind that the contracted, small, or cirrhotic white kidney does not necessarily mean a late stage of the large white kidney.

Chronic granular kidney does not include cases where the disease is on one side, which may result from obstruction to the ureters, or patchy fibrosis from gummata or infarcts, or chronic interstitial nephritis in the gout of elderly persons and in advanced atheroma. Setting these classes aside, there is a well-defined group of cases with arterio-sclerotic and renal cirrhotic characters.

The relation of granular kidney to acute nephritis is always interesting. After examining the evidence carefully, the lecturer comes to the conclusion that most cases of granular kidney must be referred to some other origin.

The arterial changes are widespread, and found in every part of the body, brain, spinal cord, eye, skin, as well as in the kidney. There are only two forms of general arterial change, namely, atheroma, and that found in granular kidney. The arterial changes in this disease are of two kinds: in the earlier period, a hypertrophic, and in the later, a degenerative, in the walls of the arteries. The hypertrophy in the arteries and heart are likely due to a common cause—some resistance in the periphery or the arterioles and capillaries. If the change in the vessels be primary, then there ought to be cases with diseased vessels before the kidneys become granular. Such cases are extremely rare, if they occur at all. No matter

whether the disease be regarded as primarily renal or in the arterioles, it should be regarded as *svi generis*, and the renal and vascular aspects studied together.

Granular kidney is a very insidious disease. The only symptom that may be noticed in the early stage is increased frequency in micturition, especially at night. This is very gradual. By the time that symptoms appear, the disease is far advanced. These symptoms fall into two groups—the cardio-vascular and the renal. The former are the earlier; and consist of heart failure and hemorrhage. The renal consist mainly of acute and chronic uremia, or better, renal toxemia.

Granular kidney is said to be disease of middle life and later, and in one sense this is true. It is, however, an extremely chronic affection, and in many cases may have commenced in early life. It is now recognized that it may begin in children.

In the early stage the diagnosis is to be made by physical signs and not by symptoms. The physical signs are high arterial tension, thickened arteries, hypertrophy of the heart and albuminuria. When these are all present the diagnosis is easy. But some of these signs may be absent. It then becomes a difficult question to decide what importance is to be attached to the remaining signs.

Vascular tension and thickened arteries develop so soon in the disease that they seem to be coincident with it; indeed some hold that they precede it. In this event vascular changes would sometimes be found without disease in the kidneys. The hypertrophy of the heart is an important sign in granular kidney in the later stages; but not so much so in the earlier, on account of the difficulty in detecting it while still slight. It must be noted that this hypertrophy is not constant, being found in from eighty-five to ninety per cent. of granular kidney cases. In many cases it has not been noted whether atheroma existed, and as this will cause hypertrophy of the heart, the value of these percentages is somewhat lost. The cardiac hypertrophy is secondary to the vascular changes, and not of the same prime importance.

Thickening of the arteries is very important. They resist pressure under the fingers, and can be rolled from side to side. When the artery is pressed by the finger so as to stop the flow through it, it still remains thick to the touch. This thickening may occur in young persons, before general atheroma is possible, and if it be not an indication of granular kidney, then there must be some other disease of the vessels with which we are not yet acquainted. This thickening may be found when nothing else can be detected, and it should arouse suspicion, for it is always pathological. When this is found, careful search will find other indications of granular kidney, or these will



develop later on. This leads to the conclusion that thickened arteries is really the early stage of the disease.

With regard to the high tension it may be remarked that in the later stages it begins to fall, and this is a bad indication. It points to neuroparalytic condition of the arteries. The high tension is favorable in granular kidney. Go back as far as we will, as soon as granular kidney can be diagnosed, there is high tension. When the tension is persistently raised it is the general opinion that it indicates the presence of the disease in the kidneys.

The question of albuminuria is one of great moment in these cases. It is usually small in amount, and often absent, but the statement made by some that it may always be absent, is very hard to prove. It may be at times abundant; but then there is some complication, as nephritis or heart failure. If we have a case of granular kidney, these variations cause no surprise, but there may be albumen, and the question is whether there is granular kidney. The person may have albuminuria and appear to be in good health. This brings us to the question of physiological albuminuria. Dr. West holds that this condition is always pathological; but he divides the condition into two forms—that from disease in the kidney, and from causes outside the kidney, as the state of the blood, or the amount of exercise. He shows that a large percentage of those with albuminuria and apparently healthy die of kidney trouble at a later period of life. It must be admitted that the presence of albumen in the urine would not enable one to diagnose granular kidney.

Another sign in granular kidney is that of albuminuric retinitis. It may be laid down as a rule that it does not occur in amyloid or acute nephritis. It is said by some to occur in chronic parenchymatous nephritis. This may be true in a rare instance, and it must be admitted that the kidney might first have been a granular, contracted one. But the fact remains that this form of retinitis is practically diagnostic of this condition in the kidneys. Further, when it does occur, with very few exceptions, the patient has not many months to live. The lesions in this form of retinitis are hemorrhages, white patches, exudations, and inflammatory conditions.

Turning from the signs to the symptoms it may be said that they fall under the headings, cardiac, vascular and toxemic.

The cardiac is in the nature of heart failure, a little palpitation and shortness of breath on exertion, or there may be pain, almost at times as severe as angina.

Cardiac symptoms are not constant, even though there is much hypertrophy. The occurrence of pericarditis is a very bad omen.

The vascular symptoms are those due to rupture and hemorrhage; those due to faulty nutrition, principally in the nervous system, through the diseased condition of the vessels; and the occurrence of aneurysm, as the lecturer pointed out that granular kidneys gave rise to this condition both in large and small arteries.

The toxemic symptoms are chronic and acute. The chronic form is in the nature of a cachexia. There is anemia and asthenia, and may be some loss of flesh. The anemia or asthenia may be extreme, and out of all proportion to the other symptoms. This chronic toxemia may cause headaches, vomiting, neuritis, renal asthma, and epileptiform convulsions. This chronic toxemia may also give rise to a number of skin diseases, as rashes with edema and rashes without edema, or irritations.

The acute toxemia is met with in the well-known uremic attacks, manifested by fits, coma, or cerebral irritation not unlike delirium tremens. These symptoms may vary a good deal. There may be very little convulsive movement, and the coma may not be extreme. The case may resemble apoplexy, in which case the prognosis is as bad as bad can be.

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## THERAPEUTICS.

IN CHARGE OF GRAHAM CHAMBERS AND J. T. FOTHERINGHAM.

### Hemophilia.

There are perhaps few disorders less amenable to treatment than hemophilia—and few for which more varied treatment has been suggested, so that we have been pleased to note in recent journals suggestions which, in the cases reported, were found useful. It will be noted that the suggestions are empirical, no fresh contributions being made to the pathology of the disorder.

In *British Medical Journal* of February 11th, 1899, Davies reports excellent results in a hemophilic family in whom tooth extraction was always dangerous, from the use of ethylchloride spray, freezing immediately the cavity from which the tooth was taken, and as he says, freezing into the cavity a hard mass of blood which acts as a tight and uniform compress. This manoeuvre has never failed him, he says. In the *Lancet*, December 6th, 1898, Dodd reports a case in which the sole surviving boy of seven, who had all bled to death, and others of whose relatives had died in the same way, was suffering from a large hematoma in the thigh, the result of a slight injury. The tumor having become infected it was incised, and the resulting flow of blood could not be stopped by packing, pressure,

internal styptics, or any known measure. When death seemed inevitable recourse was had to oxygen inhalation, and after twenty-four hours the bleeding ceased and recovery was eventually complete. One would scarcely venture to suggest a *rationale* for this treatment, but the oxygen probably kept the boy alive in spite of the loss of hemoglobin till the conditions of tension and nutrition in the vessels became such that hemorrhage ceased spontaneously. The experience of the writer in the Hospital for Sick Children here leads him to hazard the suggestion that the disease is much commoner than the books would lead us to suppose, and that the hemophilic tendency is not necessarily a lifelong condition, but that it may arise in an individual, and in the course of time disappear, leaving him normal so far as bleeding goes, for the rest of his life.

#### **Endermol—Use in the Treatment of Scabies.**

Max Mollers (*Revue internationale de Therap.*) says that of sixty-seven cases of scabies treated at the clinic of Doutrelapont at Bonn, by frictions with an ointment containing 1 per cent. of endermol, sixty-four cases were cured by one application, the other three requiring six frictions. The author prefers, however, to make four applications in every case. The ointment should be left on for two days, the patient then taking a bath and changing the underclothing. The applications caused no symptoms of intoxication or irritation in the cases treated. Endermol is the salicylate of nicotine,—*Post-Graduate*.

#### **Jambul in Diabetes Mellitus.**

Smyth (*American Practitioner and News*) earnestly commends jambul to the attention of the profession as almost specific in its power of reducing the prominent symptoms of diabetes mellitus, and of improving the general condition of people suffering from this disease. He points out the fact that Stevenson and Christy demonstrated in the laboratory that jambul when mixed with starch and diastase arrests the production of dextrose, and also that Graser and Binz found that when administered to dogs in which artificial diabetes had been produced by phloridzin or by removal of the pancreas the production and excretion of sugar was reduced eighty per cent. or more. He gives a long list of well-known European practitioners who have used it successfully in their practice, and calls attention to the fact that the Hindus are familiar with it as a remedy in this trouble under the name "djocet." The author calls attention to the necessity of giving the drug a fair trial before reporting negatively upon it, of seeing that the preparation used is not made by the aid of heat or from old stock,

of observing that some other disease is not present that interferes with results, and of being sure that the seeds are from the Java jambul. If these precautions are taken and the drug used in increasing doses, he assures his readers that "evidences of its beneficial effect will appear with a rapidity that is astonishing." Two cases are cited that came under his immediate observation. The first was that of a young man, aged twenty-four, who had all the symptoms of diabetes. He had been losing flesh rapidly and passing much sugar. In four weeks he had gained fifteen pounds; the urine was reduced in quantity, and only a trace of sugar was present.—*Medical Age*.

### A New Urinary Disinfectant.

Dr. R. W. Wilcox (*N. Y. Med. News*): The drug discussed by the author is known as hexamethylentetramin, prepared by union of ammonia and formaldehyde in solution. On account of the various ways in which this substance alters urine it has been named urotropin. From a study of its action in several cases the following conclusions are presented:

1. Urotropin produces no untoward symptoms when administered in amounts of thirty grains *per diem*.
2. It renders an alkaline urine acid no matter what the cause may be.
3. It inhibits the development of microorganisms of ammoniacal cystitis and in this way clears up cloudy urine.
4. It is indicated as a preparatory disinfectant in operations upon the urinary tract; in pyelitis, cystitis and other inflammation of the urinary tract irrespective of their cause, in phosphaturia, and in other conditions tending to formation of urinary calculi.—*Post-Graduate*.

### Tannoform.

Tannoform is obtained by the precipitation of an aqueous mixture of tannin and formaldehyde with hydrochloric acid. Tannoform has shown itself to be one of the best local remedies for decubitus, diabetic gangrene, and the many varieties of weeping, chronic, and acute eczemas. In all these cases it acts beneficially through its generally-admitted desiccating properties and its power of arresting secretion. As a means of combating excessive secretion of sweat on the hands and feet, in the armpits, and in other parts of the body it stands without a rival. In some cases a single application suffices to reduce the formation of a sweat to a desirable measure, and to suppress the disagreeable odor. Sweating feet are generally best treated with tannoform dusting-powder, which is a mixture of one part of tannoform and two parts of Venetian talc. Unmixed tannoform should only be used in very grave cases, when the

sole of the foot and the parts between the toes should be briskly rubbed with it. The same applies to the formation of sweat in the armpits, and at other parts of the body. In the cases of eczema and decubitus a 10 per cent. tannoform ointment has often been found to yield better results than pure tannoform. L. Hesse (*Australasian Jour. Phar.*, Oct. 20th, 1898).—*Sajous Monthly Cyclop.*

### Orthoform in Toothache.

A piece of absorbent cotton saturated with an alcoholic solution of orthoform and placed in the cavity is said, by Hildebrandt, to instantly stop the pain.

### The Control of Hemorrhage by Gelatin.

Lancereaux and Paulesco employ the following solution :

℞ Gelatin,  $2\frac{1}{2}$  drachms;  
Sodium chloride,  $2\frac{1}{2}$  drachms;  
Water, 1 quart.

This is sterilized, and from one to two ounces, which may be increased to three or four ounces, is injected underneath the skin of the thigh.

For combating the hemorrhage of tuberculosis it is stated that Huchard employs the following formula :

℞ Gelatin, 2 drachms;  
Sodium chloride,  $2\frac{1}{2}$  drachms;  
Water, 1 quart.

Dissolve with the aid of heat, filter and sterilize.

Commence the injections in the quantity of one to two ounces under the skin of the abdomen. Where it is desired to produce coagulation of blood in an aneurysmal sac we may employ the following solution, which is very much stronger.

℞ Gelatin, 30 grains;  
Sodium chloride,  $2\frac{1}{2}$  drachms;  
Water, 3 ounces.

Of this they give one to two ounces subcutaneously.—*Therap. Gazette.*

### The Painless Treatment of Cracks in the Nipples.

At the meeting of the Paris Obstetrical Society held on November 10th, 1898, a paper was read by MM. Maygrier and R. Blondel, upon the "Treatment of Forty Cases of Cracked Nipples at the Charit  Hospital." They had dressed the cracks

with orthoform, which brought about complete anesthesia during suckling and kept the cracks aseptic. The application of the powder causes only slight smarting. The infant was put to the breast a quarter of an hour afterwards and sucked eagerly, as orthoform has neither taste nor smell. The anesthesia persists for some time. MM. Maygrier and Blondel made trial of orthoform powder alone, of orthoform followed by a moist dressing of boric acid, and finally with a strong alcoholic solution of orthoform dropped into the cracks. They considered this last method the best, for it caused no more initial smarting, but it quite did away with infection of the breast, probably because the solution was able to penetrate into the recesses of the fissures.—*Lancet*.

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## OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD  
H. C. SCADDING AND K. C. McILWRAITH.

### The Diagnosis of Extra-uterine Pregnancy.

J. W. Taylor, in the *British Gynecological Journal*, has an exceedingly valuable paper on this subject. The diagnosis is reached from the following signs: 1. A patient within the child-bearing limits of age and one in whom pregnancy is possible. 2. She has recently been in good health. 3. It is more likely than not that several years have passed since her last pregnancy. 4. There is a history of some amenorrhea, accompanied or followed by (5) irregular uterine hemorrhage, occasionally profuse and red, but generally dark in color, moderate in amount, and persistent in its course; (6) with this there may be the history of the passage of some membrane, either in one pouch or bag as a "complete decidua," or in two pieces, or in shreds. 7. On examination, pulsating vessels may be felt in the vaginal vault on one side of the uterus. 8. On this side also, and closely investing the back of the uterus, there is nearly always a tubal tumor (this may have an exceptional situation). 9. The tumor enlarges markedly and suddenly by recurrent hemorrhages and by the formation of a hematocele directly continuous with the original tumor. 10. These hemorrhages are signaled by sudden spasms of severe abdominal pain and by transient attacks of peritonitis. 11. The uterus is displaced by the hematocele, at first backward, afterward to the opposite side of the pelvis, and sometimes forward, against the pubes (it is rare for the uterus to be permanently displaced downward); and (12) the uterus throughout, although slightly enlarged, is empty.

### Danger of Curettement after Abortion.

The following is quoted from the *American Journal of Obstetrics*: While it is undeniable that a curettement in some cases of abortion is an almost indispensable operation, it is also true that it is not as simple as is commonly supposed. The danger of a curettement of a soft, friable uterus are again demonstrated in the report of a case of Dührssen. In a case of abortion, pieces of placenta were retained in the uterus, which Dührssen and another physician attempted to remove with the curette. The placenta, however, was so firmly adherent that the operation was suspended and the uterus tamponned with iodoform gauze. Forty-eight hours afterward the tampon was removed; it was then possible to introduce the finger within the uterus and remove the particles of placenta. At the same time discovery was made that there were defects in the uterine wall, and as there was also considerable bleeding, it was deemed advisable to remove the uterus per vaginam. The examination of the extirpated organ showed that portions of the uterine wall were removed by the curette. Such an accident in the hands of so competent an operator as Dührssen should, if nothing else, lead to the exercise of the greatest care in curetting the puerperal uterus.

### The Dissection and Liberation of the Sphincter Ani Muscle.

The February number of the *Johns Hopkins Bulletin* has an article on this subject by H. A. Kelly, M.D., Gynecologist-in-Chief, the Johns Hopkins Hospital. After giving a review of the literature of the subject and describing and illustrating his own method Dr. Keily says:

The first essential difference between my own method and those of previous operators is a carefully conducted denudation, giving the sphincter a wider berth, so as to separate it from the skin surface, after all the parts have been brought into apposition, by a greater interval. This is done to make the burial of the catgut sutures a safer procedure.

The next important point is the dissection and liberation of the sphincter ends until one, or one and a half centimeters, or even more are pulled out free on each side. This has not been proposed before. The ends are then cut off so as to remove the scar tissue and then interrupted catgut sutures passed through them so as to be ready to bring them snugly together at the proper time.

The rectal wound is then completely closed by a series of interrupted sutures passed close together so as to make it impossible for any minute particles of faecal matter to press between the stitches and cause an infection. This closure is

carried down and over the anus on to the skin area, and then, only after this step is satisfactorily completed, are the sphincter ends brought together and the buried catgut stitches tied. Another point which I wish to urge, and which differs from any previous proposition, is the passage of a silkworm-gut tension suture directly through the substance of the sphincter muscle halfway between its inner and outer borders. The purpose of this suture is to take tension off the buried catgut sutures during the healing process. I prefer this suture to the Emmet tension suture which is passed well behind the sphincter ends on the skin surface, because my suture acts more directly and does not tend to make the anal orifice so small; it is, therefore, easier to secure earlier and regular defecation,

I have dwelt thus far upon the method of securing immediate union of the external sphincter muscles, it is my desire now, in conclusion, to insist upon the importance of paying equal attention to securing accurate approximation of the internal sphincter muscle. Indeed, if I would establish any comparison between the two, I would attribute more importance to the accurate union of the internal sphincter than to that of the external. This must be effected in the following manner: One or two fingers are passed into the torn bowel and then the septum is brought slightly forward, while with a knife or a pair of scissors the operator splits the septum on its mucous margin and then dissects upwards and inwards, separating the vagina and its column from the septum in such a way as to isolate the rectum in front and on the sides. By taking a little care and observing the tissues closely, the bowel with the muscle is easily set free, and if the dissection is well done the internal sphincter fibres will be clearly recognized on both sides.

After all the scar tissue is removed the internal sphincter is then united by a series of interrupted fine silk sutures entering and emerging on the mucous surface of the bowel about a millimeter from the edge of the cut. These sutures are passed and tied from above downwards from  $1\frac{1}{2}$  to 2 mm. apart.

I believe it best to reinforce these rectal sutures by two or three catgut sutures buried in the septum above them and grasping the muscular coat of the bowel, that is to say, the internal sphincter, and drawing it together over the line of union established by the first set. After doing this the external sphincter is brought together as described above, and the remaining perineal and vaginal portions of the wound united as described in the text-books. The utmost care must be taken throughout not to leave any dead spaces in the septum or about the buried sutures.

After such an operation it is my practice to open the bowels,



at least every other day, by giving a warm oil injection through a soft catheter.

### Ectopic Gestation.

In the matter of ectopic gestation Fernand Henroten, writing in "Jewett's System of Obstetrics," says:

*General Considerations.*—Surgery offers the only treatment of value in ectopic gestation prior to the fourth month. In exceptional cases operation is not advisable. *When the patient is moribund*, operation is useless. *When the patient is recovering*, watchful expectancy may be all that is necessary. A blighted ovum can unquestionably be absorbed. The patient may not come under observation until recovery is well under way. If a mass, the character of which is undoubted, is painless on palpation, is known to be decreasing in size and is becoming firmer in consistency, and if the patient presents no symptoms, under such circumstances operation would be meddling interference. *When the diagnosis is obscure* the ovum may be expelled through a patent ostium abdominal into the general peritoneal cavity and be there absorbed, or it may perish and be absorbed *in situ*, or intra- or sub-peritoneal rupture may take place and the symptoms not be sufficiently marked or severe to establish a diagnosis or to demand exploratory incision.

In the same work Whitridge Williams writes:

*Third stage of Labor.*—Excepting severe hemorrhage and cases of adherent placenta there is absolutely no indication for introducing the hand into the parturient tract. And I believe that the frequency of adherent placenta is very grossly overestimated, and in many cases its occurrence is due to the injudicious employment of Crede's method, which, in the vast majority of cases, is not necessary. The writer's practice is to watch the fundus of the uterus by placing his hand gently upon it, but not kneading it. After the lapse of 10 or 15 minutes, as a rule, we notice that the fundus rises about 5 cm. towards the umbilicus; this means that the placenta has been detached from the uterine wall and has been expelled either into the lower uterine segment or into the vagina. Under these circumstances it is ready for expression, the body of the uterus being simply used as a piston to force the detached placenta through the vagina.

## PATHOLOGY AND BACTERIOLOGY.

IN CHARGE OF J. CAVEN, H. B. ANDERSON AND J. AMYOT.

### Blastomycetes as Sources of Infection of Malignant Tumors.

Maffucci and Sirleo, of the Institute of Pathological Anatomy at Pisa, conclude (*Zeitschrift f. Hygiene u. Infectiouskrankh.*, Bd. xxvii., H. 1) that though the origin of malignant tumors from infection is not yet demonstrated, many such tumors do so arise. Certain blastomycetes have proved to be of pathological importance; the processes which up to the present they have been found to set up, in animals and human beings, have been septicæmia, suppuration, and chronic inflammatory new growth of the type of granuloma, and in anatomical construction not in any way resembling carcinoma or sarcoma. In animals liable to cancerous new growths blastomycetes taken from human cancer have as yet caused only ordinary inflammation. The presence of blastomycetes cannot always be demonstrated in human carcinoma or sarcoma by histological examination or cultivation; more easily found in malignant melanotic tumors, their topographical distribution then indicates that the infection has supervened on the tumor. That blastomycetes may cause cancer or sarcoma is possible, but has not been proved; and while the growth of papilloma, due to coccidium, shows that psorozoa may be the origin of new growth, no experiment has yet shown that they can cause cancer or sarcoma in animals capable of such growths. Research for the infectious causes of tumors should not be limited to any one class of parasite.—*Brit. Med. Jour.*, November 19th, 1898.

### Tuberculous Endocarditis.

Michaelis and S. Blum, of v. Leyden's clinic (*Deut. Med. Woch.*, September 1st, 1898) have succeeded in setting up a tuberculous endocarditis in rabbits. The authors first refer to the researches which proved malignant endocarditis to be a microbial origin. At one time it was thought that endocarditis and tuberculosis were mutually exclusive until morbid anatomy demonstrated that these two lesions might occur together. Thus out of Fromholdt's 277 cases of valvular disease 22 or 8 per cent. had phthisis. In such cases it might happen that the valvular disease occurred first and the phthisis followed, or that the endocarditis had supervened upon the phthisis. The bacteriological examination is obviously of much importance here. In some cases the streptococcus and staphylococcus have been found in the endocarditis occurring in phthisis, and more recently the tubercle bacillus. Thus in three consecutive cases of phthisis with endocarditis v. Leyden found the tubercle

bacillus in the vegetations. Michaelis and Blum set up aortic incompetence in rabbits by piercing the valves with an instrument introduced through the carotid. In about two hours later the tubercle bacillus was injected into the vein of the ear. The animal died in from three to six weeks. Besides a diffuse tuberculosis the heart was hypertrophied and dilated. The valves which had been damaged were covered with soft vegetations. The tubercle bacillus was demonstrated in them, sometimes in large and sometimes in smaller numbers. The staining of the tubercle bacillus in sections is not always quite an easy matter, and perhaps this will account for some of the negative results which have been obtained. The author's experiments show that the tubercle bacillus can by itself set up a verrucous endocarditis.—*Brit. Med. Jour.*, November 19th, 1898.

### Obstructive Jaundice in Children.

Henry Ashby records two extremely interesting cases—fatal—of the above condition. Both patients were girls—one of five years of age, the other of seven. In neither was the family history or previous personal history of any special account.

CASE 1.—Aged 5; became jaundiced when convalescing from whooping-cough; constant pain in belly; edge of liver two inches below ribs; urine and stools as usual in jaundice; five weeks after admission to hospital began to pass blood from bowel; this kept up with increasing anemia till death four months after admission, and seven after onset of jaundice. Temperature ran from 97° to 101° F.; no ascites.

*Post-Mortem.*—Liver large, dark green, no cirrhosis; lymph glands of fissure of liver, large, soft, hemorrhagic; gall-bladder small, no gall-stones; common duct surrounded by dense fibrous tissue, difficult to trace to duodenum; admitted small probe through the papillæ, and then grasped it firmly; pancreas, especially the head, indurated; duct normal. Cause of death, large hemorrhage into intestine.

CASE 2.—Aged 7; jaundice for three years before death; stools as usual; nausea frequent; swelling of feet and abdomen. Color, green; swelling of abdomen marked. On admission to hospital, emaciation marked. On withdrawing ascetic fluid from abdomen a large cyst was found on right side, lifting up the liver. Sixteen pints of green mucoïd fluid withdrawn from cyst by tapping. In next three months cyst tapped ten times, eight to ten pints of similar fluid being withdrawn each time. Cyst opened and drained; great improvement. Attempt to unite cyst to duodenum; death on second day from peritonitis.

*Post-Mortem.*—Showed liver evenly enlarged; capsule thickened; adhesions to diaphragm and spleen; sections lobulated;

color, greenish yellow. The cyst adherent to under surface of liver was the hugely distended common duct, including cystic duct and lower end of gall-bladder; hepatic duct opened into cyst. No communication with duodenum; spleen large and indurated.

Note, in Case 1, obstruction without any dilatation of duct; and in Case 2, obstruction with great dilatation of common duct.—*Manchester Chronicle*, November, 1898.

### Hysterical Paroxysmal Edema.

F. H. Edgeworth, M.B., Assistant Physician Bristol Royal Infirmary (*Bristol Medico-Chirurgical Journal*, September, 1898) records an interesting case of the above obscure disease, the history being as follows:

Male, aged 24. Plumber by trade: no family or previous personal history with any apparent bearing on the case. Came to Bristol Royal Infirmary June 9th, 1896, complaining of swelling of left arm and foot; first attack eleven years before; might go to bed well, and in the morning find a foot or arm swollen; swelling so great that he could not put on a boot if foot affected; swelling lasts all day, and then gradually subsides; burning, itching pain in the red and swollen part. At first could not indent the edematous part with the finger; as it subsided, could do so. Attacks at first separated by, say, a month's interval; latterly not further apart than a week. Any part of body might be affected, hand, arm, leg, face (often), trunk (rarely). Usually but one part swollen at once; if two parts, on the same side commonly. Health otherwise perfect. Examination showed no anesthesia, analgesia, or thermo-anesthesia; no hysterogenic zones found; reflexes of all kinds normal.

*Diagnosis.*—Vaso-motor neurosis of cerebral and probably cortical origin. Arsenic was exhibited, and apparently effected a cure.

### Lung Gangrene—Smegma Bacilli.

Pappenheim (*Berlin. Klin. Wochenschrift*, No. 37, 1898) records the finding in sputa a bacillus which, giving tinctorial reactions for bacillus tuberculosis, was set down as such, and diagnosis made accordingly.

*Post-mortem* examination demonstrated the presence of pulmonary gangrene, without tuberculosis. Further tests showed that the smegma bacillus, or a smegma-like bacillus, had been mistaken for the bacillus tuberculosis. It is well known that the bacilli of this class occur in the mouth. The case was clearly one of aspiration pneumonia with gangrene, the bacilli being present most likely as a contamination.

The danger of a mistaken diagnosis in such cases is not slight, and the necessity of a ready means of differentiating the organisms urgent. It is said by some that treatment of cover-slips after staining by fuchsin with hydrochloric acid and alcohol will always make the proof if properly carried out. *Snegina* bacilli cannot hold the fuchsin for longer than three or four minutes in presence of the acid alcohol, whereas tubercle bacilli do not lose the stain for a considerably longer period.

#### Value of Negative Cultures after Diphtheria.

In a short paper addressed to the President of the Boston Board of Health, Hibbert W. Hill, M.D., Director of the Board's Bacteriological Laboratory, shows the necessity for more than one negative culture from diphtheria patients before they are declared non-infective. His deductions are based upon some 1,200 examinations, two negative cultures being exacted before release was granted. Dr. Hill's figures prove that 35 per cent. of the releases would still have been infective had they been released after the *first* negative culture.

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### PEDIATRICS.

IN CHARGE OF ALLEN BAINES, W. J. GREIG, AND W. B. THISTLE.

#### Tracheocele.

J. Park West (*Archives*, April, 1899) reports the following case: A child, twenty months old, who has always been healthy and whose parents are healthy, when fifteen months old was noticed to have a swelling one-fourth inch in diameter a little to the left and just below the level of the larynx. At the time it was first noticed it would occasionally disappear: later it would disappear only on deep inspiration, but now it never completely disappears. It has grown rapidly for the last two months, and is now as large as a hen's egg on the left anterior neck, just above the clavicle, well separated from the larynx and trachea. It feels soft, but becomes hard and tense when the child cries. Continuous pressure will cause it to disappear, and then a thin, smooth membrane one-eighth of an inch thick can be felt. On prolonged expiration, as in crying, it is very much increased in size, and two more swellings connected with it appear. The opening in the trachea can be felt. Very few authentic cases have been reported. The author has found fifteen cases only recorded.

#### Polyuria and Incontinence as Symptoms of Adenoids.

Francis Huber (*Archives*, April, 1899) calls attention to the following symptom group: Dryness of the tongue and mouth,

parched lips with great thirst; urinary incontinence night and day. The parents are distressed and annoyed by the frequent demands for water, particularly after a few hours' sleep or on rising in the morning. The children are generally anæmic, have headaches, cardiac palpitation and sometimes night terrors. Listless and apathetic, they appear backward, with the usual facial expression of mouth-breathers. Urinary examination is negative. If adenoids are recognized and removed, all the symptoms will gradually disappear, especially if good tonic treatment is at the same time adopted. The relationship of cause and effect is apparent. He offers an explanation of the mental backwardness in the excessive carbon dioxide in the blood, and the interference with the blood and lymph circulation in the brain by the obstructed nasal respiration. These children are lacking in general innervation. They do not pay attention to their wants, and as the higher inhibitory centres are less acute, the bladder reflex is not respected, and incontinence results.

#### Black Tongue.

William S. Gottheil (*Archives*, April, 1899) describes a case in a boy two years old. Excepting the condition of the tongue, the child is now and always had been perfectly healthy. The tongue had been cleaned several times by medicine, but the color had returned in a few days. The centre of the dorsum of the tongue was occupied by a dark greenish-black streak, beginning abruptly in front of the circumvallate papillæ, and extending almost to the tip. It was three-fourths of an inch wide posteriorly, narrowing toward the tip of the organ. The rest of the tongue and the buccal cavity were normal. The black streak was slightly elevated, looked gelatinous, and its margins were abrupt; the color was most intense in the centre of the streak, and faded towards the margins. Among the scrapings were found peculiar structures, so numerous that they must be looked on as etiological factors. They lay in dense masses and heaps on the slide. Under the microscope they appeared as large, irregularly oval, semi-transparent bodies, showing a faint grey color. There were no pigment granules in them. Occasionally they were found rounded, apparently encapsuled and stratified; they were unconnected with each other, and there was no mycelium. These cases are generally associated with hypertrophy of the filiform papillæ, and hence the affection was called hairy tongue, or black hairy tongue. Numerous observers have found many different forms of fungi, and several have described a mould similar to the above. The affection is harmless, and only causes slight discontent. It is of interest from its variety.

## Correspondence.

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### PLACARDING HOUSES.

*Editors* PRACTITIONER AND REVIEW:

SIRS,—You will permit me to call attention to the question of placarding houses where there is diphtheria or scarlet fever. I am satisfied that this practice is a bad one. It can do no good, unless as a warning to others that one of these diseases is in the house so ticketed.

In the first place, many cases of mild scarlet fever and diphtheria are not reported, because of the objection to having the house placarded. I think it is not saying too much to state that in many cases, where these diseases appear to be mild, and yet the parents are fully aware of their nature, they do not call in a doctor, as they object so strongly to the placarding system. In these cases the children are around in a short time, and out amongst others, though still in a condition to infect them.

As a warning to others, it is of no value. Children will not visit in these houses though there be no placarding. People that have no acquaintanceship with the family will not be calling, and those who have will know. I am sure that as good results were obtained when the houses were not designated.

It must never be forgotten that when too stringent measures are introduced against an evil they always tend to defeat their own object. This is just what is taking place in Toronto in the cases of diphtheria and scarlet fever.

We all know how dangerous whooping-cough is to infants, and yet the disease is not even reported. No notice is taken of it, and yet it ranks third as a cause of death among children. In our desire to be doing something we are doing foolish things—and injurious things.

Yours, etc.,

SYDENHAM.

## Personals.

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Dr. F. J. Shepherd, of Montreal, visited Toronto April 4th.

Dr. T. Bedford Richardson, of Toronto, has removed to No. 10 Carlton Street.

Drs. J. W. Bruce Smith and Ingersoll Olmsted visited Toronto, April 22nd.

Dr. Edmund J. Kelly left Toronto April 5th for Edinburgh, where he expects to take a post-graduate course.

Dr. Oronhyatekha, of Toronto, returned to his home April 5th, after a two months' trip to Egypt and Palestine.

HON. DR. MONTAGUE left Ottawa, April 17th, for British Columbia, and expected to return in about three weeks.

Dr. J. T. Duncan, of Toronto, sailed from New York for England, April 15th. He will return in five or six months.

Dr. Stirling, of Montreal, visited Toronto April 1st, and was the guest of his brother-in-law, Dr. A. Primrose, for a few days.

Dr. Lesslie M. Sweetnam had a slight attack of *la grippe* which confined him to his house for a few days. He left home April 15th and went to Baltimore, where he remained a week.

DR. GEIKIE, of Toronto, after a visit to the Home for Consumptives, in Gravenhurst, returned to his home April 15th. He was very much pleased with the character of the work done in that institution.

Dr. Rowland F. Webb (Toronto, 1897), who was for some time house physician in the W.B.A. Hospital, Grand Rapids, went to Florida in the latter part of March as private physician to a wealthy American gentleman.

Dr. W. Harley Smith had a severe attack of septicemia from absorption of poison in a slight wound of the finger. His condition was considered serious for some days, but we are glad to state that he is not only out of danger but rapidly recovering.

Dr. George R. McDonagh returned to Toronto April 5th after taking a very enjoyable trip with his brother, Mr. Jack Mc-



Donagh. They sailed from New York, January 24th, visited Gibraltar, Algiers, Italy, Egypt, Palestine, Constantinople and Greece.

Dr. Henry T. Machell, of Toronto, was injured by a fall from his bicycle, April 16th. He was riding along College Street on the "devil's strip," and in turning to pass to one side the front wheel was caught by the rail, and the doctor was thrown violently on the pavement. His head and one hip were injured. He suffered from shock for a couple of hours, and afterwards from pain in the region of the hip joint. He was confined to his house for a few days, but at the time of writing is recovering rapidly.

Dr. Drummond, of Montreal, who has been called the "Robert Burns" of Canada, was entertained by the National Club of Toronto at a banquet, April 5th, 1899. In response to the toast of the evening, "Canadian Literature," Dr. Drummond referred especially to the French-Canadians and their influence in connection with the growth of the Dominion. On the following day Dr. Drummond was entertained at luncheon at the Toronto Club by Dr. Jas. F. W. Ross, who invited a number of local physicians to meet the "Habitant" poet.

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### BIRTH.

SISLEY.—Mrs. Euston Sisley, Maple, March 15th, 1899, a daughter.

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### MARRIAGES.

SMITH—DUNN.—Dr. George B. Smith, Toronto, to Miss Eva Dunn, March 29th.

MALCOLMSON—BEACH.—Dr. G. H. Malcolmson, Calgary, N.W.T., to Miss Beach, April, 5th.

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### DEATHS.

BRADD.—Only son of Dr. F. J. Bradd, Peterborough, April 12th, aged 16.

RANNEY.—Youngest daughter of Dr. Malcolm Ranney, Georgetown April 14th.

# Obituary.

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## DR. JOHN CLARKE.

Dr Clarke, of Peterborough, died at his home, April 12th. He contracted a chill a few days before his death, and acute nephritis is said to have been the cause of death. He graduated in 1872.

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## DR. HENRY P. MACKLIN.

Dr. Macklin, Medical Health Officer of Lewiston, Mich., died at the home of his father, Mr. Henry Macklin, London, Ont., August 14th. He graduated in 1891.

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## SAMUEL DOMINION DAY, M.B.

We have to announce with deep regret the death of Dr. S. D. Day, which occurred at his home in St. Thomas after a prolonged illness. He received the degree of M.B. from the University of Toronto in 1891.

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## FRED. MORSON, M.R.C.S. (ENG.).

Dr. Morson, father of Judge Morson, of Toronto, died at the residence of his daughter, in Toronto, April 22nd, aged 91. He was born in England and came to Canada in 1852. After practising for seventeen years in Montreal he retired from active work, and removed to Niagara, where he resided until last autumn, when he came to Toronto.

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## MR. STANLEY CHARLTON.

The death of young Stanley Charlton, a first-year student in medicine in the University of Toronto, was a great shock to his fellow-students and numerous other friends. He was a son of W. A. Charlton, M.P.P., for South Norfolk. An appendicectomy was performed on him a little more than a year ago. A few months ago he had a severe illness from obstruction of the bowels, as it was supposed, but temporarily recovered. Severe symptoms appeared again a few days before his death. An abdominal section was performed April 23rd, and recovery was looked for, but he did not rally, and death came the following day. He was a good student, and it was generally expected that he would be the first prizeman in his year at the coming examinations.

## Book Reviews.

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*Progressive Medicine.* A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsome bound in cloth, 490 pages, twenty-eight illustrations and three colored plates. Philadelphia and New York: Lea Brothers & Co.

The list of contributors to this first volume, issued in March, 1899, forms perhaps the best guarantee as to its excellence. They are A. D. Blackader, of Montreal, on Diseases of Children; J. Chalmers Da Costa, on Surgery of Head, Neck and Chest; Ludvig Hektorn, of Chicago, on Pathology; W. S. Thayer, of Baltimore, on Infectious Diseases, including Croupous Pneumonia (note this title); A. Logan Turner, of Edinburgh, on Laryngology; R. L. Randolph, of Johns Hopkins, on Otology.

The advent of a work such as this every three months must inevitably be a help to every practitioner wise enough to buy it. It has advantages over the annuals of the same kind, occupying indeed a different field, and not really rivalling those excellent works. The index is very full and helpful.

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*Diseases of the Eye.* A Handbook of Ophthalmic Practice for Students and Practitioners. By G. E. DE SCHWEINITZ, A.M., M.D., Professor of Ophthalmology in the Jefferson Medical College; Professor of Diseases of the Eye in the Philadelphia Polyclinic; Ophthalmic Surgeon to the Philadelphia Hospital, etc. With 255 illustrations and two chromo lithographic plates. Price: \$4 cloth; \$5 sheep or one-half morocco. Philadelphia: W. B. Sanders, 925 Walnut Street, 1899.

This third edition is an improvement on the two previous editions, each one of which was deserving of high praise. It is very complete in every detail, and shows most careful attention in regard to every subject. The whole arrangement is excellent. The style is clear, thereby making the descriptions of the different subjects easily to be understood. The great care regarding details should strongly recommend it to the general practitioner; for the absence of this care in some works on the eye is very annoying and dissatisfying. Also the generalizations are comprehensive, and

there is thus given a view of ophthalmology so complete that the reader receives a broad and accurate conception of the specialty. I can, without hesitation, recommend this edition as in every way certain to be most satisfactory to the reader. No particular part has been selected for especial notice, for in every way the work is thoroughly up to date, and should receive every patronage by the medical profession. The type and illustrations are good. It is certainly one of the very best works on the science of ophthalmology.

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*An Essay on the Nature and Consequences of the Anomalies of Refraction.* By PROF. F. C. DONDERS. Edited by CHAS. A. OLIVER. Philadelphia: Blakeston, Son & Co. 1899.

This little work is an admirable digest of Donders' classical treatise and will be welcomed by students of refraction. It states clearly and explicitly the points under consideration and will prove a valuable addition to the oculist's library.

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*An American Text-Book of Diseases of the Eye, Ear, Nose and Throat.* Edited by G. E. DE SCHWEINITZ and B. ALEX. RANDALL. Philadelphia: W. B. Saunders. 1899.

This exhaustive work has been compiled by some sixty collaborators, most of them leading men in the United States in their departments. It is, perhaps, sufficient to say that this work justifies their reputations. The book is a first-class compilation, and contains much new and original matters. The illustrations are excellent and contain many new ones. The new operations and remedies are carefully discussed and the indications are clearly pointed out. The work is one we can strongly recommend to students and practitioners in these departments of medicine.

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*Sajous Annual and Analytical Cyclopedic of Practical Medicine.* Subscription entire series only. Six volumes; one every six months. Cloth, \$5.00; half Russia, \$6.00. Monthly supplements sent free during the three years. Philadelphia: The F. A. Davis Company. Second volume, Br—Di.

A volume that is so extensive, that it contains references to every medical subject between Br. and Di. is very difficult to review. The second of this admirable series is to hand, and while some of the references are necessarily short, others are very long and complete. We are not able to point out any

omission within the range given. We note with great pleasure and instruction the exhaustive article on "Cholelithiasis," by Dr. J. E. Graham, which is a classic on the subject. It occupies twenty-one pages of the volume, and deals with both the surgical and medical aspects of the condition. All of the articles are arranged uniformly, dividing the advances year by year, enabling the reader to keep in touch with each subject in its chronological order of advancement. The article on "Diphtheria," by Drs. Northrup and Bovard, of New York, is well worth the price of the volume. These articles are monographs in themselves, and are ready references to all points. We are unable to refer to other articles, and do not pick the above from the hosts of others, excepting for their common occurrence and general interest. One of the greatest advantages of this series is that a monthly cyclopaedia is issued conjointly with the series, and keeps current literature on all subjects thoroughly reviewed, so that at the end of each year the subscriber has a complete review of the literature to be bound, and go with the series. This is a venture that deserves the hearty support of the profession, and the busier the practitioner is, the more reason he has for having this series on his desk.

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*The Pocket Formulary for the Treatment of Disease in Children.* By LUDWIG FREYBERGER, M.D. Vienna; M.R.C.P. Lond., M.R.C.S., Eng.; Clinical Assistant Hospital for Sick Children, Great Ormond Street, London. London, W.C.: The Rebinan Publishing Company. 1898.

This is a well gotten up book of 208 pages, and bound in leather. Its object is to give concisely all the information required as regards the treatment of disease in children by drugs. The drugs are arranged alphabetically in the front of the book, and the diseases in the last part. As an example of his method take atrop. sulph. The information given is under the following arrangement:

*Properties.*—White crystalline powder or crystals; soluble in 1 part of water and three parts of alcohol; taste bitter, etc.

*Use.*—Used hypodermically and internally as an anhydrotic and cardiac sedative; externally as a powerful local anodyne and mydriatic.

*Therapeutics.*—Useful in the treatment of convulsions, tetany, tetanus and trismus neonatorum, enuresis nocturna, and night sweats. Infants do not bear atropine as well as belladonna.

*Dose.*—Internally, gr.  $\frac{1}{100}$  for one-year old child; externally,  $\frac{1}{4}$  to 1 per cent. sol. or 1 per cent. ointment; hypodermically, gr.  $\frac{1}{100}$  for a child one year old, and so on.

*Incompatibles.*—Alkalies, tannic acid, etc.

*Correction of taste.*—The taste of gr.  $\frac{1}{100}$  is covered by ℥v. of syr. anantū or lingiberis.

*Formula.*—Two typical prescriptions are given, antagonists and antidotes.

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*Transactions of the College of Physicians of Philadelphia*  
Third series; volume the twentieth; January, 1898, to December, 1898.

The most important part of the "Transactions" this year is the number of papers on the subject of "Typhoid Fever." One deals with operative interference in the case of perforation and of appendicitis complicating typhoid, and two with the Brand method of treatment. The latter subject is given a most exhaustive review by Drs. H. A. Hare and J. S. Wilson, and their papers are ably discussed. To the surgeon, also, there are many papers of interest. "One Hundred Abdominal Operations," "Anomalous Positions of the Colon," "Fractures of the Internal Condyle of the Humerus" being among them. The book is a valuable contribution to medical literature.

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*Saunders' Pocket Medical Formulury.* With an Appendix containing porological table; formulæ and doses for hypodermic medication; poisons and their antidotes; diameters of the female pelvis and fetal head; obstetrical table; diet list for various diseases; materials and drugs used in antiseptic surgery; treatment of asphyxia from drowning; surgical remembrancer; tables of incompatibles; eruptive fevers; weights and measures, etc. By WILLIAM M. POWELL, M.D., author of "Essentials of Diseases of Children," etc., Philadelphia. Fifth edition. Philadelphia: W. B. Saunders.

This little book is the most compact and handy work of its kind, containing, as it does, a vast amount of useful information in a very small space, so arranged that it can be referred to in a moment. The author has taken great pains to bring it up to the present time, and to eliminate all but the essentials. The new formula will be found most useful. The dose-table has been brought into conformity with present usages.

The section on drugs and materials used in antiseptic surgery will be found most convenient.

In fact, the little book is full of accurate information, is of convenient size, well printed and nicely covered. It will be an accurate guide and useful book for the purpose intended and altogether is a credit to the author and publisher.

*Essentials of Bacteriology*: Being a concise and systematic introduction to the study of micro-organisms for the use of students and practitioners. By M. V. BALL, M.D., Bacteriologist to St. Agnes' Hospital, Philadelphia. Third edition, revised, with 81 illustrations, some in colors, and five plates. Philadelphia: W. B. Saunders, 95 Walnut Street. 1897.

A mere condensation of large reference books, which in the process has retained much that is useless and spoiled that which might have been useful. With neither wit nor judgment in selection the compiler has sent forth a volume which is anything but what the introduction claims it to be.

When shall teachers realize that by pandering to the "loafer" they are ruining student and lowering profession?

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*The Ready Reference Hand-book of Diseases of the Skin*. By GEORGE THOMAS JACKSON, M.D. (Col.), Professor of Dermatology in the Woman's Medical College of the New York Infirmary, and in the Medical Department of the University of Vermont; Chief of Clinic and Instructor in Dermatology, College of Physicians and Surgeons, New York; Member of the American Dermatological Association and of the New York Dermatological Society. With seventy-five illustrations. Third edition, revised and enlarged. Lea Brothers & Co., New York and Philadelphia. 1899.

The fact that the first edition of this book appeared in 1892, the second in 1896, and the third in 1899, indicates that the work has been well received by the medical profession, and has given the author an opportunity to increase its value, not only by revising many of the sections, but also by adding descriptions of recently described diseases, such as Blastomycetic Dermatitis, X-Ray Dermatitis, Bulpiss, etc.

The general plan of the work—the arrangement of diseases alphabetically—remains the same, and forms in our opinion the principal objection to the book. We believe that the first principle in teaching any branch of medical science is to place before the student the best possible classification founded on a pathological basis, and we therefore could not recommend this work as a text-book for undergraduate students. Still, it has many commendable features. The illustrations are better and more numerous than those which are generally found in a volume of this size. The author's method of describing the symptomology is quite clear and satisfactory, and his treatment is both rational and practical. The appendix contains a long list of prescriptions which have been tried and proved of value by dermatologists. The volume, taken as a whole, can be safely recommended to physicians and will prove a very useful reference hand-book.

*Fractures and Dislocations.* By PROF. DR. H. HELFERICH, of Griepswald. Illustrated with sixty-eight plates and 126 figures in text, drawn by B. Keilitz. Translated from the third edition (1897) with notes and additional illustrations, by J. Hutchinson, jun., F.R.C.S., Surgeon to the London Hospital. 162 pp., 8vo. Price by subscribing for 1898. Annual subscription \$5.72, postage free. London: The New Sydenham Society. Publisher, H. K. Lewis, 136 Gower Street, London, W.C.

The New Sydenham Society completes its fortieth year with 1898. The volumes of this year are "Lexicon of Medical Terms" (twenty-fourth part), "Atlas of Pathology" (Fasciculus XII, Hodgkin's Disease), and the work under review. The volume requires very little introduction; it is indeed a classic. The text is written in a most fascinating manner; the illustrations are far superior to the average, while the skiagraphs are gems, all strikingly illustrative of the subject under consideration. The author treats all fractures as complicated or uncomplicated, which greatly simplifies matters, and abandons the terms simple, compound, and comminuted. The complicated fractures are those in which other tissues than the bones are involved. The fractures are of course presented in their numerous conditions, from the incomplete or greenstick to the different degrees of complete fracture.

The author "strongly recommends the more frequent use of anesthesia in suspected cases of fracture." This we consider of great importance. The true condition is arrived at without inflicting unnecessary pain to the patient, and without the resistance that the painful manipulations are bound to occasion. Great stress is laid on the completeness of examination. Cases of fracture being reduced while dislocations were overlooked are cited, and the subsequent discovery is very unpleasant to the surgeon in charge. The whole work is complete and a great addition to any library.

The advantages of belonging to the New Sydenham Society are not well known to the practitioners in Canada. We append some general information. The subscription is one guinea annually, in Canada \$5.73, including postage, to be paid in advance to Mr. H. K. Lewis, the society's agent. Members who subscribe for the current year and not fewer than three past years at the same time, will be allowed to select volumes from the surplus stock to the value of one guinea without additional payment. Arrangement have been made by which new members can obtain single volumes, or sets of volumes, from the society's stock in hand. Some of the volumes, of which a larger surplus exists than others, can be purchased at fixed prices. The society's agent is empowered to make special



arrangements with new members who may wish to obtain any of the past volumes. The society's works are supplied free of cost to any address in Canada for the yearly subscription of \$5.73.

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*Chemistry.* General, Medical, and Pharmaceutical, including the Chemistry of the United States Pharmacopeia; a Manual of the Science of Chemistry and its Application in Medicine and Pharmacy. By JOHN ATTFIELD, F.R.S., Ph.D., (Tübingen) F.I.C., F.C.S. For thirty-four years Professor of Practical Chemistry to the Pharmaceutical Society of Great Britain, 1862 to 1896; formerly Demonstrator of Chemistry at St. Bartholemew's Hospital, London; Honorary Member of the Pharmaceutical Societies of Great Britain, St. Petersburg, Austria, Denmark, America, etc.; Honorary Member of the College of Pharmacy of Philadelphia, New York, Ontario, etc.; Editor of "British Pharmacopeia," 1898. Sixteenth Edition. Philadelphia and New York: Lea Brothers & Co. 1899.

This book is so well known to the medical and pharmaceutical professions that a review of the work appears almost unnecessary, and therefore we shall only refer to its most salient characters. The volume is intended for the use of students of medicine and pharmacy, and covers in a way the whole field of medical chemistry, inorganic and organic, as well as qualitative and quantitative analysis, and includes the chemistry of both the British and United States pharmacopeias. Although we have always looked upon the book as the most useful work of its size in applied medical chemistry, still we would never think of recommending it to medical or pharmaceutical students beginning the study of general chemistry. The author's method of presenting the subject is considerably different from that which is followed, or should be followed, at the present day. He gives very little attention to the natural classification of the elements, and rarely refers to the relations of the elements of the different groups which, according to the opinion of the best teachers of chemistry, are two principles which should never be lost sight of in successfully teaching the subject. The chapters on organic chemistry would be much improved if more attention were given to the description of the groups of compounds taken as whole before describing the chemistry of their principal members. The sections on analyses are accurately written and are of sufficient length for a work of this kind. The book, taken as a whole, is a first-class manual of applied medical chemistry, and we believe that we can safely state that a pharmacist library would be incomplete without it.