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CANADA

MEDICAL JOURNAL

AND

Monthly Record

OF

MEDICAL AND SURGICAL SCIENCE.

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CANADA

MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

Puerperal Convulsions without Albuminuria (in a case of twins,) treated by Chloroform and the Artificial Induction of Labour. By DONALD MACLEAN, M.D., L.R.C.S.E., Professor of the Institutes of Medicine, and Lecturer on Clinical Surgery, Queen's University, Kingston.

Case.—Mrs. C., (Township of Storrington) aged 32. Pregnant for the sixth time, has had twins once before.

All her previous pregnancies and confinements having been, so far as she is aware, quite normal. Her general health has always been excellent, until within the last three months, during which she has been subject to severe attacks of neuralgia in the head, face and neck. Six weeks ago she applied to me on account of one of these neuralgic attacks, and I succeeded in instantaneously arresting her severe sufferings by the hypodermic injection of solution of morphia.

The respite lasted for a fortnight, but at the end of that time she again applied to me and with the same result, by the same means as on the previous occasion.

I heard no more of her until the 29th ult., when her husband called on me and stated that Mrs. C. had been suffering very severely from neuralgia in the head, neck and left shoulder for several days, and that on the previous day (Sunday the 28th) spasmodic movements (twitchings) had appeared in the left arm, that these movements, as well as the neuralgic pains had gradually increased in violence, until sometime through the night, they culminated in what appeared to him a regular epileptic fit, which left her in a state of stupor, from which she had not altogether recovered when he left her early on Monday morning.

I at once suspected puerperal convulsions and acceded to Mr. C's. request, to see her as soon as possible. We arrived at Mr. C's. house, which is twelve miles distant, at 2 p.m. on Monday, and found the

patient in a strong convulsion, which the attendants informed us was the third since Mr. C. left home.

I immediately administered chloroform with the effect of arresting the convulsion and setting her to sleep. She slept soundly and naturally for more than an hour, and then sat up in bed and conversed with remarkable intelligence and cheerfulness. She informed me that she was just entering upon the eighth month of pregnancy, that she thought the child was dead and had been so for some days, and that she had felt for some time that "all was not quite right." She attributed all her present troubles to a fall from a buggy some weeks previously, since when she had not felt right. It was soon after this fall that the first attack of neuralgia came on. During the three hours that I stayed with her on Monday there was no return of the eclampsia, but the twitching of the left arm continued; otherwise she appeared quite well, the neuralgia had entirely disappeared, and she partook of some refreshment with a relish.

On examination, I found that the fœtal heart was beating a little to the left of the middle line, at a point about three inches above the pubis. I could hear it only in this situation, so did not suspect the presence of twins, although the uterus was unusually distended. At this time there was no appearance of labour. Having given the nurse full directions how to use the chloroform if the convulsions returned, and having procured a small quantity of urine to test for albumen, and to examine microscopically, I left her and came home.

The urine contained neither albumen nor casts, on the contrary appeared to be quite normal.

Early on Tuesday morning a messenger came from Mr. C., with the information that Mrs. C. was much worse, (the fits were becoming gradually more and more frequent, and the chloroform had lost its effect,) and a request that I should lose no time in visiting her. At ten (a.m.) I found her to all appearance "in extremis." The convulsions were very violent and almost unintermitting, pulse nearly imperceptible, extremities cold, no signs of labour coming on. The attendants stated that she had been quite insensible since three o'clock (a.m.), and that the chloroform had no effect in arresting the fits. Notwithstanding this latter very discouraging statement, I determined to resort once more to chloroform, and the result was that in a very few minutes all reflex action had ceased, and the patient lay perfectly quiet, but in a condition very closely resembling coma.

After the lapse of ten minutes, the arm began to twitch violently, and it was evident that another fit was coming on. The chloroform was immediately resumed, and very soon the patient was quite quiet once more.

The fit appeared to have been summarily arrested by the anæsthetic. By this time I felt convinced that the cause of all the trouble was the over-distended condition of the uterus and that the only course for me to adopt with a view of saving the life of the mother and child was to remove the cause, by artificially inducing labour. This I at at once proceeded to do by introducing into the uterus a flexible catheter and by injections of cold water into the vagina, the fits being kept in check meanwhile, by chloroform.

In a short time, I was gratified to observe the uterus contracting and the os uteri sensibly dilating. The latter process I endeavored to promote by digital pressure.

So soon as the os had opened to rather more than the size of a half dollar silver piece, I ruptured the membranes, when an immense quantity of water gushed forth and an arm presented.

I attempted to perform podalic version, but found myself unable to do so, (no doubt on account of the presence of a second child,) but the os was now nearly fully dilated, the uterine contractions were very strong and frequent, and the child very small; I therefore used the crotchet and delivered the child double. As soon as this child was born there was another great gush of liquor amnii, and on introducing my hand a second child was found, presenting by the feet, and was very rapidly born, and almost simultaneously the double placenta was expelled, without any flooding, the uterus contracting as rapidly and firmly as could be desired. Both children were alive, and though very small and evidently premature, seemed likely to live.

The mother was kept thoroughly under chloroform until the binder was applied, and some of the wet bedding replaced by dry.

When the chloroform was removed, which it was at 1 p.m., there was no appearance of a return of the convulsions, but the patient was hardly conscious, she was in a state of stupor which lasted for fully thirty-six hours, during which, when spoken to in a loud voice, she would say, yes or no to any question, which admitted of being thus replied to; but any question requiring a longer reply she did not attempt to answer.

For twelve hours after parturition she appeared to be very thirsty, asking frequently for "drinks."

On Tuesday evening she fell into a calm and natural sleep, and with the exception of occasional attacks of twitching in the left arm, all reflex action had ceased.

On Wednesday, I was prevented from seeing her, but received a note from Mr. C., informing me that mother and children were progressing favorably; that the former, though still oppressed by the stupor, was

looking fresher and more natural than she did the day before, and that there had been no return of the fits.

On Thursday I visited her and found everything going on well, (except that one of the twins had died convulsed a few hours before my arrival). Mrs. C. had had her bowels freely opened by castor oil.

She looked remarkably well, pulse about 100. She had completely wakened out of her lethargic state, had asked for chicken soup. Still the twitching of the left arm continued, and she complained of great weakness; her skin was dry and harsh, for which I ordered sponging with tepid water and vinegar, after which she felt much more comfortable in consequence no doubt of the slight diaphoresis produced.

On Sunday, the 4th inst., I saw her for the last time; all reflex action had now ceased, and she was evidently making rapid progress towards recovery.

Since then, Mr. C. and others have called here and reported always most favorably as regards the mother, but the other child died on Thursday the 8th in the same manner as his brother had done some days previously.

I ought to observe that at each of my visits to Mrs. C., a specimen of urine was obtained and examined, chemically and microscopically, but nothing abnormal could ever be detected.

Commentary. This case undoubtedly constitutes an exception to the great general rule that "Puerperal convulsions are intimately connected with diabetes albuminosus or acute Bright's disease."

True, some eminent authorities as Marchal, Liebert, Depaul, Legroux, L'Huillier, Stoltz, Seyfert, Levy & Scanzoni, have assailed the theory of the identity of uræmic intoxication in acute Bright's disease, and puerperal eclampsia, but equally eminent writers as Frerichs, Litzman, Braun, Wieger, Oppolzer, Matthews, Duncan, and many others have, with equal ability, and I think better success, defended this theory, for at the present day it is the generally received view.

The first mentioned authors have endeavoured to prove that the Brightian degenerations of the kidneys, which, it cannot be denied, are found in the bodies of those who have died of eclampsia, are consequences merely of the convulsions only accidental secondary phenomena of the hyperœmia caused by the eclampsia, and of hydroæmia."

The result of analytical investigations is thus summed up by Scanzoni:

"1. In the most recent times the *post mortem* examinations of persons dying of eclampsia have shown, only in a minority of cases, so profound a degeneration of the kidneys, as to justify the diagnosis of Bright's disease.

"2. It is not proved that albumen in the urine and the presence of fibrin cylinders always precede the outbreak of the convulsions. On the contrary, there are circumstances which show that this anomaly is frequently developed for the first time during the delivery or the convulsions.

"3. The arguments which have been brought forward to prove that uræmic intoxication has taken place, are not by any means equally strong arguments for our holding that the true eclampsia parturientum is always the result of uræmic intoxication originating in Brightian degeneration of the kidneys.

"4 Eclampsia puerperalis presents general clonic convulsions of the voluntary muscles, proceeding from the spinal cord, with removal of consciousness. These convulsions have their immediate cause in the irritability of the motor system of nerves which has been induced by pregnancy and increased by the act of delivery."

The case of my patient, Mrs. C., would seem to give support to the above views.

That she suffered from true eclampsia cannot be doubted, and still, so far from the convulsions being preceded by the presence of albumen and of fibrin cylinders in the urine, these abnormal phenomena were not observed at any period in the history of the case. It certainly seems impossible to account for the convulsions in this case in any other way than by "the irritability of the motor system of nerves which had been induced by pregnancy," and not only of the motor, but also of the sensory system. The neuralgia from which Mrs. C. suffered was the first palpable evidence of that nervous irritability which resulted directly from the unusually great distension of the uterus, and which in the end culminated in true eclampsia.

Dr. Braun, in his text-book of midwifery, (Lehrbuck der Geburtshulfe mit Einschluss der operativen Therapeutik, der ubrigen Fortpflanzungs-funtionem der Frauen und der Peurperal processe Von Dr. Carl R. Braun, K.K.O.O., Professor der theoretischen Geburtshulfe und Geburtshulflichen Klinik fur Arzte an der K. K. Universital in Wein, &c., Wein, 1857) devotes one chapter to the subject of puerperal convulsions, which chapter, owing to its completeness and erudition, has been translated into English and published in a separate form by Dr. Matthews Duncan, Lecturer on Midwifery, &c., &c., Edinburgh. From this translation the following graphic description of uræmic eclampsia is quoted; and I may here observe that this description applies with singular exactness to the convulsions which I observed in my patient, Mrs. C.

"(Uræmic eclampsia occurs in every period of pregnancy, as well as at other times, and even in males.) It is distinguished by quick repetition of the fits and complete insensibility during the fit, as well as generally during the interval. The face and neck appear swollen and injected during a paroxysm.

"The eyelids are prominent, and open or closed; the eyeballs exhibit quick rolling motions in the most different directions, or are fixed in an upward stare." (The latter was the case with Mrs. C.; the upward stare was well marked.) "The vessels of the conjunctiva are mostly injected; the mouth is at first widely opened and distorted; the tongue is protruded; then trismus follows, in which, if proper care be not taken, the protruded tongue is often bitten through, and hence a bloody foam flows from the mouth. In the muscles of the face, lively distorting convulsions are observed, whereupon the upper extremities get bent, the trunk is twisted to one side, and then all the extremities are thrown into jerking motions. Respiration often altogether ceases for many seconds. The carotids show strong pulsation; the veins of the neck and face swell on account of stoppage of the blood from muscular spasms. The colour of the face is cyanotic.

"All the muscles of respiration, especially the diaphragm, are in a state of contraction; and, in consequence of this, asphyxia may occur. The urine and fæces are involuntarily excreted. Vomiting rarely precedes the first fit. The skin remains dry, or may be covered with perspiration, and its temperature is either increased or diminished.

"The reflex sensibility is suspended during the fit. The pulse is frequent or slow; the arteries small or large. After this group of symptoms, there follows a soporose condition, in which the patient continues for a shorter or longer time, and lies motionless; the extremities stretched out and stiff; the respiration frequent and difficult, and at first stertorous, afterwards slower and snoring. Generally there is absence of consciousness and sensation.

"After awaking, patients generally complain of a confused, dull headache, and of great languor, which continue till a renewal of restlessness, stretching, extending, slow, tremulous bending of the upper extremities, jerking of the facial muscles, with reddening of the face, announce a new paroxysm. The fits may be repeated several times in a day – sometimes as much as seventy times. Generally after a few fits complete unconsciousness supervenes, and this continues till recovery or death."

In cases where such a train of symptoms is observed, Dr. Braun (and others) maintain that acute Bright's disease is almost invariably present, that it "is the first link of a chain of morbid changes leading on to

puerperal convulsions" (Braun on Puerperal Convulsions, translated by Dr. J. Matthews Duncan, page 32). We cannot, at present, attempt to follow Dr. Braun through all the arguments which he advances in support of his position. There can be no doubt that the weight of evidence is in his favour; at the same time, the opinions of such men as Marchal, Liebert, Depaul, Legroux, L'Huillier, Stolltz, and Scanzoni are not to be lightly laid aside. Cases such as the one above related, in which there is eclampsia, without any evidence of renal disease, may be rare; nevertheless they do occur, and they go far to lessen the importance of Bright's disease as a cause of puerperal eclampsia. Moreover, it is admitted by Dr. Braun himself that, "As regards the *proximate* cause of the uræmic intoxication in Bright's disease, conjectures only can, at present, be expressed; for acute Bright's disease is not always accompanied by uræmia and eclampsia. Of 100 cases of acute Bright's disease only from sixty to seventy are seized with uræmic eclampsia.

"Of cases of eclampsia eighty per cent. occur in first pregnancies, in which, on account of the greater resistance of the abdominal walls, a powerful counter-pressure on the kidneys is generally produced.

"In cases of repeated pregnancy the pressure connected with a pleural pregnancy, with depressed pelvis, hydraminos, large size of the fœtus and a high position of the womb are frequently met with where eclampsia occurs." (Duncan's translation, pp. 22 and 24.)

Dr. Braun's researches have undoubtedly thrown great light upon this intricate and most important subject, nevertheless much remains to be done before the pathology of puerperal eclampsia is thoroughly understood.

In conclusion, with regard to the question of treatment, I wish to make a few observations.

In the case of Mrs. C., the chief means resorted to were chloroform inhalation and the artificial induction of labour.

The medical treatment recommended by Dr. Braun is the same, whether the eclampsia occurs in pregnancy during labour or in child-bed. He says, "The chief object to be attained is to diminish, as much as possible, the reflex excitability, to weaken the paroxysms, in order to diminish the dangers and to gain time for entering upon rational treatment. In this respect we have observed results from chloroform-narcotism which have surpassed all expectations. In uræmic eclampsia, the chloroform-narcotism is to be induced instantly when indications of an impending paroxysm show themselves—as great restlessness, increasing rigidity of the muscles of the arms, expiry of the intervals between former paroxysms, fixity of expression, or tossing hither and thither.

The narcotism is to be kept up until the premonitory symptoms of the paroxysm disappear and quiet sleep follows—a result generally attained in one minute.

"But, if it be not possible to cut short the paroxysm, then the chloroform inhalation is not to be kept up during the convulsive attacks and the comatose condition, in order to let an abundant supply of fresh atmospheric air reach the lungs. The chloroform inhalation moderates the imminently dangerous cramps of the muscles of the neck, epiglottis, and tongue, and may be continued even during a persistent trismus, when other medicines cannot be introduced into the stomach, and when loud mucous rôles indicate the development of œdema of the lungs.

"To moderate the secondary congestions of the head, which come on during and after the paroxysms, the application of ice is useful, and also smart sprinkling with cold water; and, better still, the cold douche on the head, during which operation the head of the patient is held over the side of the bed, and the ice-water falls into a basin held beneath it.

"Sponging the skin with tepid vinegar produces a most desirable diaphoresis and is easily accomplished. General depletion of blood easily produces an injurious effect in uræmic eclampsia, because, by bleeding the hydroæmia is further increased, the nervous fits are not improved, puerperal thrombosis and pyæmia in child-bed are much to be feared; and, because not unfrequently the paroxysms are aggravated by it, and exhaustion, fainting, and very slow convalescence are thereby produced.

"A great number of physicians consider prompt, careful evacuation of the uterus as the main point in the treatment of eclampsia. Artificial premature labour is to be resorted to only when there is some probability of the mother being thereby saved, and so much the more if death of the fœtus has already occurred.

"Colpeurysis and uterine catheterization we consider in this case the most secure method."

The efficiency of the method of treatment recommended by Dr. Braun was well illustrated in the case of Mrs. C. The same principles of treatment apply to all cases of true puerperal convulsions, whether connected with Bright's disease or not. The undue length to which this paper has extended, and for which I beg to apologize, has prevented the quotation, in full, of Dr. Braun's observations on the subject of treatment. For having restricted myself to quoting his words in reference to this part of the subject, I am sure no apology need be offered.

Quinine and Iodide of Potassium in Acute Rheumatism. By E. LEMIRE, M.D., attending Physician to the Grey Nuns and Providence Dispensaries.

The use of quinine and iodide of potassium in the treatment of acute rheumatism is not a novelty, nor an unknown fact, as almost every author mentions it, although they have employed those agents separately. There is not perhaps any disease so frequent, so suffering, and for which no given mode of cure has yet been discovered. Why is this? Is it because the disease is unknown? No, as Aritie mentions it, since the highest antiquity; after him Sydenham, and many others since that time. Is the nature of the affection so obscure that no appropriated treatment can be discovered? I should think not, as almost all authors agree in considering the affection as a special inflammatory disease or a phlegmasia *sui generis* whose manifestations or symptoms are so well defined that any mistake in the diagnosis is rather impossible. The reason of this is perhaps, in the fact that every author thinks his own way of curing a disease better than any other, or would be hurt in his *self-love* in giving credit to another for his innovations. Some of them, as *Chomel*, would treat the affection with few bleedings and mercury; *Bouillaud* says, bleeding (saignée coup-sur-coup) is sufficient. Others will prescribe only the *alkalies*, Valleix quinine. I think that in medicine more than in any other science, it is rather difficult to be positive; and to heal an affection with a treatment always the same is impossible. First, because the disease varies often according to the *idiosyncrasy* of the patient, and sometimes on the sickly conditions under which he stands. Then rheumatism being a special disease, no mode of cure having yet been discovered, wisdom tells us to have no invariable treatment, but to choose amongst them all, or combine them to obtain our design, that is *cure*. Every one knows the ordinary duration of the disease. Some say nine days, as *Bouillaud: Pinel*—six to sixty; *Chomel* says that he has seen it continue for three months; but the general opinion, I think is from the twentieth to the thirtieth day. This long duration of the disease is perhaps the cause of the numerous and various treatments practised. The physician, bearing in mind to save suffering to his patient, varies his treatment until he produces the effect he desires. It is known that *quinine* given in large doses, as *M. M. Briquet and Monneret* prescribe it, shortens very much its duration. Some years past Dr. Levins of Liverpool has combined quinine with iodide of potassium, and this, he says, with the best result. He never prescribes more than two grains of the former with five grains of the latter.

Parting from this fact, I have tried the treatment, varying a little in the dose, and far from claiming any credit for myself in the success, but only with the view of corroborating facts, I give you the following case of acute rheumatism treated by the combination of quinine and iodide of potassium, thinking it my duty, as every forward step made to shorten the duration of such a suffering disease is worthy of notice.

The fifth of May last Mr. W., a stone cutter, was seized with acute rheumatism, the disease affecting the ankles, the knee joints, wrists, and one shoulder—strong odourous perspirations, and tongue white coated. I immediately opened the bowels with five grains of calomel and twenty grains of jalap and ordered the following mixture, sulph. quinine ℥ j., iod. potassium ℥ ij., acid sulp. dil. ♏ ss. aquæ ℥ viij., a tablespoonful to be taken every four hours. Six days after—that is the eleventh—the patient left his bed, walked on the twelfth about his room, and two days after was out and perfectly cured. Two other cases that I have had last winter went on very near as well, the patients being out ten days after the beginning of the treatment. As I have said, I do not claim any credit for the success, knowing that perhaps at the next occasion the same treatment will fail; but I thought I did right in mentioning it, as the result is as good as by any other mode of treatment.

Case of Traumatic Inflammation of the Knee-joint. Recovery without anchylosis. By HERBERT H. READ, M.D., L.R.C.S., Edinburgh.

On August 2nd., 1864, I was called to Leonard R., aged 12, whose right knee-joint had been opened three days previously, by a transverse incision on the inside of the joint. The cut was an inch and a half in length, and part of it was in the line of articulation. Synovia had escaped, and his uncle, who carried him into the house, could see into the cavity of the joint through the gaping wound. An attempt was made to keep the edges together by strips of plaster, but it was ineffectual, and when I saw him, they were three-fourths of an inch apart, and the wound was filled with healthy granulation. There was neither pain, swelling nor redness about it, and I drew the edges of the cut together, and maintained them in opposition by long strips of plaster, afterwards applying the long splint.

August 10th, severe pain suddenly seized the knee, followed in a day or two by a great swelling. I saw him on the 13th, found him suffering intense pain, the knee greatly swollen, the wound gaping widely, and filled by a dense slough which I divided.

The inflammatory fever was of course great. I directed poultices to be applied, gave him a sedative and diaphoretic mixture, with chlorodyne at night. and put the leg on the splint recommended by Mr. Barwell for the hip-joint disease.

Saw him again, August 26th. The wound was discharging freely, pain and swelling still great, and he was much emaciated, and worn out. This state of things continued for some days when the pain and discharge lessened. They subsequently returned with great force, though while the discharge was at its height the pain ceased. Shortly afterwards the flow gradually decreased, and in ten weeks from the receipt of injury, the wound was entirely healed; the inflammation had gone, and his appetite and strength were returning. The splint was still kept on until he began to sit up. I saw him again January 28th, 1865.

The knee was swollen considerably on both sides of the patella, which floated loosely. There was no tenderness on pressure. *He could bend the leg nearly to a right angle with the thigh.* He limped but slightly, and had been driving a team in the woods more than a month. I have not seen him since; but during this month his brother informed me that now the wounded limb is nearly as good as the other, and the motion in the joint is nearly as great as in the sound one. His only inconvenience is, that continued exertion and exposure to cold cause pain in the knee.

I attribute the favourable result in this case mainly to the use of Barwell's splint.

Windsor, Nova Scotia, June 19th, 1865.

HOSPITAL REPORTS.

Caries of the heads of the Metacarpal bones of the right hand. Under the care of Dr. Fenwick. Reported by Mr. R. S. Parker.

J. B., aged 25 years, native of Ireland, was admitted into the Montreal General Hospital, May 1st, 1865.

He is a man of delicate conformation, scrofulous taint, and has a tendency to phthisis, though there is no apparent disease of the lungs.

The patient belongs to the City Police force; and in July of last year, while in the discharge of his duty, he received a blow from a whip handle on the ulna side of the right hand, which did not, however, prevent his arresting the prisoner, a carter, who thus energetically resisted his authority. The following day the part was swollen and stiff, and he suffered considerable pain of a burning character. On application to the

police surgeon, the hand was freely painted with tincture of iodine, and he was enjoined rest. He was altogether about six weeks off duty, during which time various means were resorted to, such as the frequent application of iodine, cold douche, &c., but no internal remedies were employed. At the end of this period the swelling was somewhat abated, but the part was still exceedingly tender and the fingers very stiff. This state of things continued for some months, when about the early part of January, 1865, an ulcer formed on the back of the hand about the middle of the metacarpal bone of the ring finger; at the end of a few days a second ulcer formed over the head of the metacarpal bone of the little finger, the edges were raised and indolent in appearance, and had a tendency to spread. They were treated by various lotions and unguents which would reduce the ulceration in size, but only for a time, as they invariably broke out afresh. Worn out with pain and discouraged by the results of treatment, he applied for relief at the Montreal General Hospital, when he came under the observation of Dr. Fenwick, who diagnosed caries of the heads of the metacarpal bones.

May 2nd.—*Operation.*—Having been carefully placed under chloroform an incision was made along the outer side of the hand extending from the base of the little finger to near the styloid process of the ulna. The metacarpal bone was at once exposed and found denuded of its periosteum and extensively cariesed; it was with ease separated from the adjacent parts, snipped across about its centre and removed; the bone of the ring finger was also found diseased; and in like manner with more difficulty, however, treated in the same way, less of the shaft requiring removal. No further disease being apparent, the wound was stuffed with lint, and water dressings employed. On the second day after the operation the fingers were supported by a gutta-percha splint, as the little finger had a tendency to fold under the others. During the operation the tendons of the muscles were carefully pushed out of the way; in fact they were not seen if we except the extensor tendon of the little finger which came into view, but was uninjured. The case progressed most favourably, the wound rapidly filled up, and the ulcers on the hand disappeared. The patient was placed on generous diet with quinine and iodide of potash; and passive motion was enjoined at the end of three weeks. He was discharged cured on the 17th June, with a most useful hand; the fingers are foreshortened, but he enjoys free motion, can write with comparative ease, and expressed himself quite satisfied with the result of the cure. The case is of interest as showing the amount of injury and destruction of parts liable to occur from a comparatively trifling blow. It is somewhat singular that the matter which must have

formed beneath the periosteum should have taken four months to shew itself, as appears from the history of the case. It is possible that the action was slow from the fact of the man's health being by no means good; still from all we can learn, he had lost considerable flesh, and had suffered much constitutionally from the continued annoyance, both mental and physical, of the disease. The result has been very satisfactory, as is attested by the man's improved appearance and the restoration of a useful hand. The removal of the limb had been recommended by one surgeon, which had greatly affected his spirits.

REVIEWS AND NOTICES OF BOOKS.

Lectures on Surgical Pathology. By JAMES PAGET, F.R.S., Surgeon to St. Bartholomew's Hospital; revised and edited by William Turner, M.B., Lond., F.R.C.S.E., F.R.S.E., Senior Demonstrator of Anatomy in the University of Edinburgh. Third edition; Philadelphia, Linsday and Blakiston. 1865. Montreal; Dawson Brothers.

There is certainly no English pathologist who has attained to the eminent position now held by the distinguished author of the above volume of lectures on Surgical Pathology; and this position has been gained after years passed in toil and unwearied exertion in the special department to which he has devoted his great talents and energies. Perhaps there is no special subject in medical science, which requires more labour, more thought, and in which there is a greater field to theorise, than that of Pathology. True, a pathologist should take his ideas and his deductions from nature—and nature deals in facts, yet, the plenitude of these facts give room, when the mind is imaginative,—to theorise. We would not condemn a theorist, for without them we would often feel at sea; yet too much theory is apt to make practice uncertain and defective. Mr. Paget has, so far as we have been able to examine his large volume of between seven and eight hundred pages, avoided this, to our view, dangerous tendency. With the magnificent museum of the Royal College of Surgeons, England, at his disposal, as one of its professors, and his experience gained while surgeon at St. Bartholomew's, he had facts sufficient, and with them he has mainly dealt. When theory has seemed essential, his deductions are well drawn, with a true connecting link between fact and theory. In these lectures, first delivered before the College of Surgeons, between the years 1847–52, when the

author was professor of Anatomy and Surgery to the college, there is an ease and a grace running through them which indicates the accomplished scholar. The present edition has been revised under the direction of Mr. Turner, the able anatomical demonstrator of the University of Edinburgh. In the preface under his signature Mr. Paget says, "I was anxious that they should be revised with all the light of the knowledge of pathology acquired since their publication, yet a thorough revision of the whole subject was a task for which I feel unfit. For in the passage of nine years I had been carried into the active practice of my profession; and at the end had not sufficient time, for either studying or thinking carefully about the many facts and probabilities, and guesses at truth which had been added to pathology: I was therefore glad to be able to commit the work of revision to my friend and former pupil, Mr. Turner, whom I knew not only to be very conversant with the progress of medical science, but able to test others' observations by his own. It is not for me to say, how well he has done his work, for I have so worked with him, as to be equally with him responsible." The first two lectures are devoted to nutrition—then follows several on growth, healthy, and diseased. On the subject of fatty degeneration, Mr. Paget says:

"The whole history of fatty degenerations concurs to prove that they are the result of defects, not of disease, of the nutritive process; and that they may therefore be classed with atrophy which we recognize in merely diminished quantity of formation. * * * On the whole therefore we must conclude that something much more than general tendency to form fat, or a general excess of fat in the blood, is necessary to produce a local fatty degeneration. The general conditions are favourable, but not essential to this form of atrophy. * * * The most common form of fatty degeneration is that in which you find, on opening the heart that its tissue is in some degree paler and softer than in the natural state, and lacks that robust firmness which belongs to the vigourous heart. But what is most characteristic is, that you may see especially just under the endocardium spots, small blotches or lines like undulating or zig-zag, transverse bands of pale, tawny, buff, or ochre-yellow hue, thick set, so as to give at a distant view, a mottled appearance. These manifestly depend, not on any deposit among the fasciculi, but of some change of their tissue. For at their borders you find these spots gradually shaded off, and merging into the healthy colour of the heart; and when you examine portions of such spots, with the microscope you never fail to find the fatty degeneration of the fibre. The yellow spotting or transverse marking of the heart may exist in the

walls of all its cavities at once, or may be found in a much greater degree in one than in others. It may exist on all parts of the thickness of the walls, or may be chiefly evident beneath the endocardium and pericardium." It is far less common in the auricles than in the ventricles, and when it exists simultaneously in all parts, is less advanced in the auricles. It is more common in the left ventricle than in the right; and in the left ventricle it is commonly most advanced on the smooth upper part of the septum and in the two large prominent fleshy columns. Indeed it may exist in these columns alone; and when, in such a case, the rest of the heart remains strong, may account for the occasional occurrence of rupture of the column.

"These yellow spottings of the heart, produced by degeneration of scattered portions of its fibres, are, as I have said, the most evident, as well as the most frequent, indications of its degenerative atrophy. But a similar affection may exist in a worse form, though it be less manifest; worse because the degeneration is more extensive and less distinctly visible to the naked eye, and must be recognized by the touch rather than by the unaided sight. The whole heart feels soft, doughy, inelastic, unresisting, it may be moulded and doubled up like a heart beginning to decompose long after death; it never seems to have been in a state of rigor mortis."

These extracts, briefly describing the two principal varieties of fatty degeneration, give but a faint idea how the subject is handled by our author. We will give but one other extract, and that concerning a question, regarding which there is some difference of opinion; we refer to the method by which fractures are repaired.

"A subject of chief interest in the repair of fractures is the position of the reparative material. * * * There are two principal methods. In one the broken ends or smaller fragments of the bone are completely enclosed in the new material. They are ensheathed and held together by it, as two portions of a rod might be by a ferrule or ring equally fastened around them both. In such a case the new material surrounding the fracture has been termed "provisional callous or external callous;" but the term ensheathing callous will, I think, be more explanatory. In the other method the new material is placed only between those parts of the broken bone whose surfaces are opposed; between these it is inlaid, filling the space that else would exist between them, or the angle at which one fragment overhangs another, and uniting them by being fixed to both. Reparative material thus placed may be called intermediate callous. * * * * The method of repair with an "ensheathing or provisional callous" is rarely observed in man, but appears to be frequent in fractures of the long bones in animals. Mr. Paget then describes the repair

in animals, stating he has never seen it as a natural result in man, in any bones, but the ribs, and that in the human subject bones are repaired by "intermediate callous."

We have not space to follow our author further, but we may remark that almost every subject in surgical pathology is touched upon, and we need hardly add, treated with wonderful ability. Every physician and surgeon wishing to post himself in all the latest pathological facts, would do well to obtain a copy of this work.

A Monograph of Glycerin and its uses. By HENRY HARTSHORNE, A.M., M.D. Philadelphia: J. B. Lippincott & Co. 1865. Montreal: Dawson Brothers.

This is a most unpretending little volume of about seventy pages, on glycerin, its history, properties, manufacture, chemical relations, adulterations, tests, medical uses, &c. It is only about ten years since this useful agent was to be obtained in anything like purity, although its primary employment as a medicinal agent dates some ten years earlier. Its progress as a pharmaceutical agent has been slow, and among medical men there has apparently been a strange indifference to its employment. Even in some affections, where its efficiency has been proved beyond the shadow of a doubt, perhaps some have tried an impure article, and met with disappointment. Now, however, that glycerin can be obtained perfectly pure, and the means of testing it are well understood, and very simple, we believe it is but just entering upon the wide field in which, we have no doubt, it will be found extremely valuable. Glycerin is perhaps one of the most elegant menstrua for the preparation of microscopic objects, its use in this respect far surpassing Canada balsam, at least so far as our experience extends. It is not alone as a remedial agent that glycerin is to be regarded. In combination with belladonna, it forms one of the most elegant and useful applications as an antilactescent—and in various applications for diseases of the skin it enters largely. It is said that the manufacturer of spurious wines owes to glycerin the oily appearance by which the fluid adheres to the glass,—a circumstance looked for by connoisseurs and regarded by many as an evidence of the genuineness of the liquor. Mr. Hartshorne's little volume is a complete compilation, and gives an insight into the numerous uses to which glycerin may be put. All who are desirous of obtaining an insight into the uses of this agent, will find in this little book all that is necessary to know. We can confidently recommend it to our readers. To be had of Dawson Brothers, Great St. James street.

Medical Lexicon.—A dictionary of Medical science containing a concise explanation of the various subjects and terms of Anatomy, Physiology, Pathology, Therapeutics and Pharmacy, Surgery, Obstetrics, Medical Jurisprudence, &c., &c., &c. The accentuation and etymology of the terms and the French and other synonms so as to constitute a French as well as an English Medical Lexicon. By ROBLY DUNGLISON, M.D., LL.D., Professor of Institutes of Medicine Jefferson, Medical College, pp. 1047. Philadelphia: Blanchard and Lea. 1865. From the publishers.

This is perhaps the book of all others which the physician or surgeon should have on his shelves. It is more needed at the present day than a few years back, as it seems to be the rage of the profession, as it certainly is the practice to coin new words. The ordinary reader becomes intensely disgusted or most thoroughly mystified in taking up a modern work on any of the subjects connected with medical science. The host of new terms in use are perfectly amazing; for ourselves, we have always regarded our own mother tongue as quite sufficient, and therefore are not desirous of stretching into the labyrinth of speculation in search of some compound which is calculated to mystify and render obscure our noble art—but our simple code is not in general use, therefore it becomes necessary to have the key to the many terms employed and adopted by teachers and writers in medicine. To our readers we can confidently recommend this volume; the explanations are clear, concise, and we have examined it in many parts in search of words, the very meaning of which we did not know, and our friend came to our assistance with a full and clear explanation. It is to be had of Dawson Bros., Great St. James Street.

Lectures on Public Health, delivered at the Royal College of Surgeons, Ireland. By E. D. MAPOTHER, M.D., Professor of Hygiene, and Health Officer for the city of Dublin. Dublin: Fannin & Co. From the Author.

It is the pride of the present age that we are immeasurably in advance of those who, centuries ago, trod this same earth of ours. If, however, we surpass them in the speed of our travelling, in our mode of instant communication with distant parts, it is certain that we are far behind them in almost every measure which relates to the sanitary condition of the masses. To prove the correctness of this fact we need only look at the fulness and positiveness of those Mosaic laws which refer to public health. None more appropriate to people living in the same climatic

conditions could be devised; and to-day in classic Rome the ruins of gigantic aqueducts and sewers, attest the knowledge of sanitary measures by heathen Rome. In this particular we have indeed, we believe, degenerated, and we must confess that our hopes of a speedy reform are not of the most brilliant character. It is hard to convince those in authority, and still more so the public, that thousands of lives are actually wasted each year in every large city, simply from the neglect of proper sanitary precautions, and yet such is the truth. Is it not proven by the fact that in certain cities where sanitary reform has been attempted through the agency of a properly qualified health officer, that the ratio of the deaths has decreased—as much as twelve per cent, in some. Let us take Liverpool, a large sea-port town, inhabited by natives from every clime. In 1842 one third of its labouring population lived in cellars about twelve feet square, sometimes less than six feet high, often without windows, and only lighted and ventilated by a door, frequently below the level of the street. In 1846 its death rate was 38, but owing to the philanthropic labours of the late Dr. Duncan, in carrying out improved sewerage, closing of cellar dwellings, preventing overcrowding, and at once separating contagious disease, it has been reduced to twenty-four or less than two-thirds its former rate, thus saving to the city annually 4,000 lives hitherto actually wasted. Does not this single instance—and we might quote others—prove incontestably that any city neglecting the sanitary condition of its inhabitants, is acting most unwisely, we may, with truth, say acting most insanely. The mortality of Montreal is vastly too great—year after year hundreds of lives are wasted, which might be saved, had those whose duty it is to attend to such things but devoted a little of their energy in the proper direction. We have been in habitations where dwelt the semblance of humanity—places not fit for the brute creation—perfect pest-houses to the entire neighbourhood—places that the city should have authority to demolish at a week's notice; and we believe these remarks apply to every city in the Province. When our City Council have a proper appreciation of the benefits that may be had from sanitary science, they may, perhaps, learn that Montreal may be rendered less unhealthy, and see the necessity which exists for the appointment of a health officer—an office similar to that held by Dr. Mapother, whose able lectures we have perused with great pleasure. They were delivered last fall at the College of Surgeons, Dublin, to mixed audiences, and embrace, among other subjects, air, its impurities, ventilation, disinfection; water impurities; food, its physiological purposes; healthy skin, baths, clothing, sanitary architecture, dwellings, sewerage, &c., &c., &c.

Such a volume is capable of doing a vast amount of good; and so con-

vinced are we of the benefits likely to result from its perusal, that we would urge every one who can to obtain a copy—especially those in authority. It is not at all expensive, and our publishers, Dawson Brothers, will be glad to import any number of copies. Our apologies are due to its talented author for the delay which has occurred in the noticing of his work. Our only excuse is that we wished first, to read the volume carefully through, and various unforeseen circumstances have hitherto prevented our doing so.

PERISCOPIC DEPARTMENT.

Medicine.

TYPHUS FEVER.

In the *Lancet* Dr. Gairdner remarks upon the causes of this disease that as many cases as possible should be left to their natural course, unaffected either by drugs or stimulants, and that he is convinced of the safety and expediency of leaving many cases of typhus to take their *normal* course; he further believes the normal course may be very easily altered for the worse by what is called treatment; and in particular, as regards the period of the crisis, that the habitual or constant exhibition of drugs and stimulants has a great tendency to mask the disease, to disturb or to retard the crisis, and by so doing to increase the mortality. He is satisfied that there are many practitioners who scarcely ever see a normal case of typhus, owing to their perpetual and systematic interference by drugs and stimulants; and it is even a question with him if the written descriptions of previous epidemics have been largely vitiated by this cause, the disease being to some extent, as it were, disguised or perverted from its natural and favourable course by the treatment.

"There are, however, one or two further precautions that must be taken before you can hope, I do not say to avoid disturbing the crisis in typhus fever, but to avoid killing your patients outright, or rather letting them die of sheer neglect. You must feed your patients, and you must feed them chiefly on milk. Milk or buttermilk is with me the staple food in typhus; and I will even say that I know no other food that can be depended on. Yet I see, and always see with a new surprise, descriptions of the treatment and dioteties of fever in which not a word is said about milk, and a great deal about beef-tea, wine, whiskey, brandy, and all manner of things supposed to be more strengthening or stimu-

lating than milk diet. Now, I tell you frankly that treating fever patients without plenty of milk is a thing that I do not understand at all; for I suppose I have not treated a single case of fever of any kind for the last fifteen years (I cannot make precise statements beyond that date) without milk, and I always proceed on the understanding that milk in fever is the one thing needful as diet—always to be given and given liberally, whether specially ordered or not. To give wine, whiskey, and beef-tea, while withholding milk, is simply, in my opinion, to destroy your patient; and the more wine or whiskey you give, while withholding milk, the more sure you will be to destroy your patient soon, because you are thereby superseding the natural appetite (or what remains of it) for a nourishing and wholesome diet—if it can be so called by a diet—which poisons the blood and checks the secretions, and alters for the worse the whole tone of the nervous system and of the digestion and assimilation. I believe that infinite mischief has been done in typhus fever, and in all fevers, by giving wine, and by withholding, or not giving milk. Under a false theory of administering alcoholic food, it has resulted, not that only natural and genuine food has been withheld, but that the small remaining amount of appetite for such food has been obliterated, and not unfrequently, even at an early stage of the disease, the patient has been practically disabled from taking any proper nourishment at all.

CLINICAL LECTURE ON VENESECTION.

By W. O. Markham, M.D., Physician to St. Mary's Hospital.

Gentlemen,—I have to-day to bring under your notice two cases which, as I think, illustrate in a striking way the beneficial effects of venesection. In both cases, the patients were suffering, and suffering severely, from lung diseases; and in both the symptoms for which the venesection was practised were those which represent in a marked degree interference with the free play of the heart and lungs. I will, in a few words, relate the history of these cases; and then make a few remarks touching the operation of the venesection in their cure.

J. J., aged 36, a healthy man, was seized about a week before his admisson into St. Mary's Hospital, with difficulty of breathing and "stitch" in the right side. These symptoms increased up to the time when he entered the hospital. When I saw him, the morning after his admission, he was sitting up in bed, fighting for breath, and, as he expressed it, felt almost suffocated. His pulse was rapid; his tongue moist and coated, and his face livid. He had been delirious during the night. An examination of his chest, hastily made, showed us that he was the subject of

double pleuro-pneumonia, and that there was complete dulness on percussion before and behind over at least three-fourths of the right lung. Now, if ever one might venture to predict, from a consideration of symptoms and physical signs in such a case, that the patient was being surely and rapidly asphyxiated; and that, unless some immediate and great relief were quickly given him, he would inevitably perish, assuredly one might have done so in this case. Guided by this impression, and considering that the man had only been ill a week, and had previously enjoyed good health. I ordered him to be bled at once, and freely bled—*i. e.*, until he showed signs of relief or fainting. I may here remark, as a curious sign of the times we live in—of the revolutions which periodically occur in medicine, as well as in all other things—that the house-surgeon had never bled a patient, nor had seen lancet used in bleeding! About sixteen ounces of blood were taken from the man's arm, to his very great and immediate relief. The pain in the right side (where the pleuritic symptoms were most acute) returned again in the evening, and therefore some eight or ten leeches were then applied. Next morning, the man was, comparatively speaking, in a most comfortable state. He no longer suffered from those urgent, and, as I deemed them, fatal signs of distressed breathing, which afflicted him the day before.

And what had brought all this so great relief to him, if not the venesection? Surely, if in any case we may draw conclusions that the relief given in disease was the result of the remedy administered, we may do so in such a case as this, where the nature of the disease is so manifest, where the relief following the remedy is so undoubted, and where it follows so immediately upon its use. More than this; it may be asked, Is there any other remedy besides venesection which could in such a case have produced relief so great, and so immediate? Well, then, unless we choose to shut our eyes to as palpable a fact as any which can be produced in the matter of the action, of therapeutical agents, it seems to me that we are driven to the conclusion that venesection is, *in such a case*, the most sovereign and life-saving of remedies; that, in the instance before us, it had rescued the man from impending death. I do not intend to follow out the history of this man's case through his long convalescence. I will only add that, in addition to the double pleuro-pneumonia, he was afterwards attacked with pericarditis; and that subsequently a pleuritic abscess of the right side opened into, and discharged its contents through the lungs and the trachea. Notwithstanding all this long catalogue of serious affections, he eventually left the hospital convalescent.

The other patient, alluded to as illustrative of the beneficial uses of venesection, was an adult man, who had occasionally suffered from "asth-

matic" symptoms. When he entered the hospital, he breathed with much difficulty, and, in fact, suffered "excruciating" pain in the left side. His respirations were 50 in a minute, and his pulse very rapid. His disease was pneumonia of the left side. He was immediately bled to about fifteen ounces, and was as immediately relieved of his great distress. I will only add of him, that he thereafter rapidly and satisfactorily recovered from the attack, and left the hospital cured.

Now, I call your attention to these two cases, because they seem to me, as far as they go at least, to show the error of the present "extreme in practice," which virtually abolishes venesection from our list of therapeutical agents. I believe that in one of these cases, at all events, the man would inevitably have perished, had he not been bled.

You know the modern theory about bleeding, or rather I should call it the present prevailing theory; for it is no way modern. It is this: that diseases have changed their type: and that men of these days will, therefore, not bear bleeding as men did thirty or forty years ago. I have elsewhere shown, as I think, demonstratively, that this theory is a mere scapegoat which men have made use of as an apology for their own apparently inconssistent conduct—in order, in fact, to explain how it is that they no longer employ venesection as they once employed it in other and darker ages of medicine. I have asked and sought for the *proof* of the assertion that men will not bear bleeding now as they did in those other days; and I find it utterly wanting. I find that the assertion is founded on some indefinite kind of belief—on ordinary medical belief—in fact, on mere surmise and opinion. If you ask men for anything like reasonable *proof* of the opinion, you ask in vain. I showed, in the lectures referred to, that this idea of an incapacity of a man to bear bleeding was flourishing upwards of a hundred years ago—has, indeed, flourished at intervals during all ages, and has been handed down from physician to physician through generations past. A hundred years ago, Hunter tell us that some of the physicians of the day discovered, just as physicians of our day have done, that diseases would not bear bleeding as well as they did formerly. Medicine is continually repeating its own errors. At this moment, however, I only ask you to keep these two cases—surely I may call them these two facts—in your eye, when you may be tempted at some future day, and in an urgent case, and contrary to your own judgment, to forego venesection solely because you have a dread of this bugbear of a change of type in disease—of some modern incapacity of human nature to bear loss of blood. Just reflect again on what you here see going on around you daily and hourly in this matter of loss of blood. Look at patients, after accidents, lying in our surgical

wards blanched through loss of blood. Note the enormous quantity which wells away from women during labour; measure the black vomitings of patients suffering from ulceration of the stomach, and the bloody sputa sometimes thrown up in tubercular disease of the lungs; note the large dejections of blood which often accompany ulceration of Peyer's glands in typhoid fever: note all these, and many other sources of often most copious hæmorrhages which you see going on daily under your eyes in the hospital; and note also that these patients recover, and recover rapidly, from the effects of such large hæmorrhages. Mark how little they exhibit of that incapacity to bear loss of blood which they ought to exhibit if there were any truth in the theory that we are now living in an asthenic phase of diseases. More than this: I might ask you to observe the very great relief which these spontaneous hemorrhages often bring with them, especially in those cases of disease in which the lungs and the heart are concerned.

Well, gentlemen, if you will note all these facts, and then carefully reflect upon them, and you will, I am sure, at all events, have your belief greatly shaken in the truth of the idea that to take a few ounces of blood from a man by the lancet is something akin to taking the very life out of his body. These reflections will shake your confidence in the truth of the theory upon which is based the modern practice of non bleeding in disease. And then if you will also call to mind the markedly beneficial effects following the bleeding, and noted by your own eyes, in the two cases here spoken of, you may probably be induced, on proper and fitting occasions, not to fear to resort to this most excellent of remedies. This is the lesson which I have wished to impress upon you to-day.

And one word more, let me say, as to the probable action of the venesection in cases of this kind. The idea generally entertained on this point is, I believe, quite erroneous, and, what is worse, an error, which prevents the use of the remedy. It is thought venesection is of service in inflammatory diseases, through the beneficial influence which it exercises over the local inflammatory process. I believe there is no proof whatever that venesection has any directly beneficial influence over any inflammatory process. If venesection be of service in internal, it should equally be of service in external, inflammations—*i.e.*, in those inflammations whose progress we can see with our eyes. But in what records of "bleeding" times, will you find any satisfactory proof that it ever was of service, in such inflammations? and where will you find an authority of the present day to tell you that he has seen the benefits of venesection in external inflammations?

The truth is that, in past days, when venesection was in its glory—I

mean gloriously abused—you will ever find that its benefits were most loudly proclaimed in those internal inflammations in which the action of the lungs or heart were impeded; and, assuredly, at the present day, there is never any pretence or thought of bleeding a man, except in those diseases in which the respiratory or circulatory organs are directly or indirectly affected. Facts like these, and other facts which I have not time now to tell of, indicate *a priori* the correctness of the proposition I here make to you,—viz., that venesection has no directly beneficial influence over the inflammatory process itself; but that it is of benefit, by removing some of the accidents which arise secondarily out of those inflammations and diseases—viz., the impediments to the free play of the lungs and heart. No one ever did, or ever does, think of bleeding in pneumonia unless the pneumonia be so extensive as to seriously interfere with the play of the heart and lungs. Men always did, and always do, judge of the necessity for the venesection by the amount of impediment to the action of those organs displayed in the physical signs and symptoms which indicate the impediment and the nature of it. The benefits of the bleeding, as I see the thing, are not the result of any good effected by it at the seat of the inflammation—of any good directly effected by it over the inflammatory process. Its benefits are rather to be ascribed to the freedom of action —the relief given by it to the play of the other, the uninflamed parts of the lungs, and the engorged heart—of the organs or parts in fact which have become secondarily engorged—*i.e.*, impeded in action, in consequence of the inflammation. The bleeding neither arrests nor alters directly the condition of the inflammatory process.* It neither cuts the inflammation short, nor can it remove the exudations which are the necessary attendants of inflammation. In what possible way can bleeding alter directly the condition of a consolidated portion of lung? In the case of J. J., the bleeding most assuredly effected no instant change in the state of the inflamed parts of the lungs and pleura. But nevertheless the relief given by it was immediate—came whilst the blood was flowing from his arm—as it always probably comes, if the bleeding be of any service at all. Also, remark that the relief here given is just of the same kind as that which is given in cases, for example, of chronic diseases of the heart, and of thoracic aneurism; in cases where impediments to the action of the heart and lungs, or, in other words, congestion of the heart and lungs, have suddenly arisen, and where inflammation does not exist. Hence, therefore,

* Of course excepting in so far as by modifying the general state of the system, it may modify the general forces which are concerned in or preside over the process.

when bleeding is of service in the course of inflammatory diseases it is so, not because it directly alters the inflammatory process, but because it relieves certain of the accidents which arise incidentally out of the inflammatory process—*i.e.*, the congestion of the heart and lungs. Bleeding therefore, it may be said as a corollary of this, is of service only in those inflammations and diseases in the course of or out of which arise impediments to the play of the heart and lungs.

But, after all, let no theoretical arguing draw us away from the patent fact which we have seen with our eyes. We saw a man, to all appearances *in extremis*, fighting an unequal battle with disease. We found him to be the subject of double pleuro-pneumonia. We saw an immediate stop, then and there, put to the violence of this deadly struggle by bleeding. We saw the man recover from the moment of the bleeding. You may have heard him declare that the bleeding was the saving of his life —though you need not perhaps take any great account of a patient's opinion on such a point. You have seen all this. Well, gentlemen, I trust I have sufficient sense of the fearful amount of fallacies which beset our medical reasoning—of what Dr. Barclay calls our "medical errors" —I believe I have a sufficient dread of the proverbially reigning confusion in our ideas of the *post hoc* and the *propter hoc* in matters therapeutical. But I think a man must be sceptical indeed, beyond all bounds of reason and common sense (if we may invoke that sense here), who refuses to connect effect with causation, the consequence with the antecedent, the cure of the disease with the venesection, in the cases I have to-day brought under your notice. And this one other word let me add suggestively, What other remedy do you know of under the sun which is capable of producing off-hand, then and there, such great results in such formidable disease?—*British Medical Journal.*

THE BLISTER TREATMENT OF ACUTE RHEUMATISM.

(Case under the care of DR. DAVIES of the London Hospital.)

The profession will welcome any new and reasonable therapeutical means in the treatment of a disease so common and so dire in its effects as acute rheumatism. Few diseases add so largely and in so many ways to the mass of human suffering. Although it rarely kills, it frequently incapacitates the patient for active life, and, besides, it is the parent of many other definitive diseases—as chorea and paralysis. In itself, or so far as the patient knows, it is a mere question of a few weeks' severe pain. Although in great distress and helpless, he is nearly certain to get through it. And at one time, before its connection with heart affection

was known it was not thought by medical men to be a very serious disease. No treatment, however, can be worthy of the name which does not tend to keep off cardiac complication. To do this ought to be the great object of all treatment, and any plan that falls short of it, however much it may relieve the patient's suffering, is a failure. In spite of all that has been done in the treatment of this disease, we are continually meeting with cases of heart disease in the out-patient's department of our large hospitals.

Now, most physicians are agreed that one important way of preventing cardiac complication is to cure our patient quickly. To do this many plans have been urged, and the most recent is that brought forward by Dr. Davies—viz., by free blistering. We think that by far the most important statement in his paper is—"In no case when the heart was sound at the time of admission did any organic lesion develop itself." We may just add, however, that there are few diseases about which there are more flatly contradictory opinions as to the results of any particular method of treatment than acute rheumatism. Thus the alkaline treatment is much relied on by many physicians, but at Guy's Hospital we see cases treated by Dr. Gull by a placebo—*e.g.*, a little extract of taraxacum and water. This physician avers that this no-treatment, or rather no-drug-treatment, is quite as good as the alkaline method. He speaks from experience, as he has carefully tried both. The patient gets well, he believes, as soon, and the heart is as seldom attacked, under one as under the other. Dr. Davies' plan seems to us to be a medium betwixt drug treatment and what we may call treatment by time. We shall give, next week, particulars of two cases under the care of Dr. Greenhow, followed by remarks by that physician, in which it will be seen that the results were favourable. Dr. Davies' plan has been tried with success in other hospitals, and we shall report, shortly, a case treated by Dr. Jeaffreson, in St. Bartholomew's. Many cases have been treated in the London Hospital since Dr. Davies' paper appeared, and we now give the following example:—

The most striking feature in Dr. Davies' method of treatment is, that it is absolutely and entirely local. In the cases he relates, no drugs, except an occasional purgative, were given. Wherever a joint was inflamed, there a blister was put on. The blisters are to be applied quite round the affected limb; not on, but near to, the inflamed joint. When a large joint like the knee is affected, the blisters should be two inches wide. They should be put on, he says, at "the very height of the inflammatory stage, when the local pains are the most severe and the constitutional disturbance the greatest." Poultices should be afterwards

applied to prevent flow of serum. In one case nearly 300 square inches of blisters were applied. It may be thought that, as regards pain, the remedy is worse than the disease, but the contrary is the fact. The patients like the blister treatment, and it has never caused strangury in any of Dr. Davies' cases, except to a trifling extent in one case.

This seems at first sight a strange way of treating a blood disease like acute rheumatism, but, as Dr. Davies' shows, under this treatment the urine will become neutral or even alkaline. So then, the treatment, although local, produces that condition of the urine which is generally aimed at in the common treatment by alkalies. Dr. Davies uses local means, as he thinks the poison locates itself in the inflamed joints. He believes, indeed, that the blood is not loaded with the *materies morbi*, but that it is deposited in certain tissues which have temporarily an affinity for it. Instead, then, of giving alkalies to *neutralize* the "acid poison," he thinks we should try to *eliminate* it by blisters applied near the points where it is then accumulated. Whether Dr. Davies' theory of the action of his remedy be correct or not, the practice seems to have been very successful, and is deserving of careful trial in our hospitals. It is purely a question of fact. Does the blister treatment shorten the duration of acute rheumatism and prevent heart complication? If further experience shows that it does accomplish these two important objects, Dr. Davies may be congratulated on having increased the powers of usefulness of our profession in no small degree.

The following case is supplied to us by Mr. J. E. Adams, assistant-resident medical officer to the hospital:

Ann S., aged 25, married, was admitted November 30th, for acute rheumatism. It had begun eight days before, and was her first attack. Her health had usually been good, but lately she had been weak—*i.e.*, since her confinement three months before.

When admitted, she had all the constitutional symptoms well marked. Her tongue was furred, there was great thirst, complete anorexia, she could not sleep, her pulse was 108, and temperature 100°; secretions acid. There was intense pain in both shoulders, both hips, in the left wrist, hand, knee, and ankle, and they were hot and swollen. There was also a very soft systolic murmur audible at the apex of the heart. Blisters were at once applied to all the affected joints, ten in number; and no medicine was given beyond an opiate at night.

Next day there was very little pain in the blistered joints, but the hand was now affected. The constitutional symptoms were about the same, but there was slight strangury. Two blisters were ordered for the right hand. The next day there were no rheumatic pains, the pulse was

diminished in frequency, tongue cleaning, but there was little sleep, and the appetite had not returned. The sweat was still slightly acid; urine and saliva neutral; strangury very slight. Two days later the pulse was reduced to 80; temperature 99°. She had passed a comfortable night, and the appetite was returning.

From this time she improved steadily (having only once a little pain in the left elbow, but no constitutional disturbance) and left the hospital on December 20th, perfectly well, the condition of the heart being the same as on admission.—*Medical Times.*

ON THE BEST METHOD OF DETECTING SMALL QUANTITIES OF ALBUMEN IN THE URINE.

By Andrew Clark, Assistant-Physician to the London Hospital.

It is of great clinical importance to possess a simple and certain method of detecting small quantities of albumen in the urine. After a great variety of experiments, I have come to the conclusion that nitric acid used in the manner about to be described—a modification of the plan suggested by Heller—is by far the most sensible, reliable, and handy agent that can be used for this purpose by the physician.

Pour not less than half a drachm of *fuming* nitric acid into a test tube; incline it, and then let a like quantity of the suspected urine trickle down *very slowly* to the acid, over the surface of which the urine will float without the slightest admixture. If albumen be present, a milk-white, sharply defined, tolerably tenacious film will form at the exact point of junction of the two fluids. This film is never, at first, thick; and when the amount of albumen in the urine is extremely minute, it may be so thin as to become visible only by reflected light when the test tube is inclined. Occasionally, when very thin, the albuminous film is dissolved in the course of a few hours. Commonly, however, it increases in breadth, diminishes in density, becomes yellow or yellowish-green at its under surface: and throws off minute coagula, which fall through the acid to the bottom of the tube.

Nitric acid used in this manner as a test for albumen is also a test of the presence of uroxanthine, or bile—either or both of which are not unfrequently present in temporary and functional albuminuria.

If, in immediate contact with the acid, a ruby or violet ring is developed, uroxanthine is present; and bile also, if in addition to a red or violet there is formed likewise a green-coloured ring, which remains for some time.

Two feasible objections are urged against depending solely on the employment of nitric acid in the manner described, as a test of the

presence of albumen; and I have myself noticed a third; but a careful examination of their force leads me to the conclusion that they are more theoretical than real.

When urine, rich in uric acid or its salts, or containing much scaly epithelium, is poured over cold nitric acid, a general turbidity arises, which is said to be undistinguishable from that produced by the presence of albumen.

But if the proposed test for albumen be properly applied, no turbidity will be produced by the presence of that substance, unless urates are also present. And then the white film of albumen is separated from the superimposed turbidity by a thin stratum of clear urine.

The turbidity produced by uric acid or epithelium is general, granular-like, and without any approach to coherence.

The turbidity produced by urates is sometimes abruptly defined below by an opaque, ring-like border, sometimes colored, sometimes not; but a stratum of clear urine intervenes between this rink and the surface of the acid, and, as above, the turbidity has no cohesion of parts. Besides this, the turbidity produced by lithates may be immediately dissipated by heat; and, if not in great excess, even by the heat of the hand closed around the tube.

The film produced by the contact of nitric acid with albuminous urine is quite different from any kind of turbidity. Confined to the layer of urine resting upon the acid, white like a disc of compressed cotton, tenacious, and, when shaken with its associated fluids, breaking into flaky fragments, it seems improbable that any but the merest tyro should mistake it for anything but what it is.

In testing for albumen by means of heat and nitric acid, there may be no immediate response indicative of its presence; and yet after a few hours, a flocculent precipitate may form and fall to the bottom of the tube.

A specimen of urine examined within an hour after extrusion from the bladder, may yield unequivocal evidence of the presence of albumen, and cease to do so after twelve hours.

Small films of coagulated albumen produced on the surface of nitric acid, occasionally disappear within a few hours from the time of their formation.

Little importance is to be attached to the presence of small quantities of albumen in the urine of women a day or two before or after menstruation. It is common without any disorder of the kidney, or any sensible discharge from the vulva.

Small quantities of albumen are often present in the urine of women with leucorrhœa, and of those who have recently had fits of hysteria

One is not justified in asserting the absence of albumen in the urine upon the result of one or two examinations. I knew a case in which albumen occured in the urine daily for several months; but it was present only in the urine first passed after breakfast, and was never, to the time of its departure, present in the urine passed at any other time.

Men sommetimes discharge a thin whitish glairy fluid with the closing stream of urine in the act of emptying the bladder. This fluid is said to be seminal; but in none of the examples that I have examined were any spermatic filaments present. From its containing mucin, and young cell particles, I look upon it as an augmented and slightly altered secretion of the glands opening into the urethra. When discharged in any quantity, the urine containing it responds to all the ordinary tests of the presence of albumen.

Albumen in small quantities and unaccompanied by casts, may be present in the urine daily for three years, and at last permanently disappear. This occurred in a case under my observation. The health which had previously been bad, rapidly improved after the disappearance of albumen from the urine, and became ultimately very good.

Mere hepatic congestion is sometimes the cause of slight functional albuminuria. I had under observation for some time a lady whose "liver attacks" were invariably preceded by the appearance of small quantities of albumen in the urine. With the free purgation which was found necessary for the removal of these attacks, the albumen disappeared. I remember also the case of a gentleman who was subject to somewhat similar attacks. In his urine, however, free uric acid was associated with the albumen, and both stayed several days beyond the subsistence of acute disorder. But he was a wilful patient, and chose to live well even at the cost of being ill.—*Clinical Lectures and Reports of London Hospitals*, 1864.

Surgery.

A CASE OF LIGATION OF THE COMMON CAROTID ARTERY.

J. P. M. Gray, M.D., California, Mo.

On the 15th day of March, 1865, Mr. Salisbury was brought into my office by a gentleman who held his hand on the neck, as he said, to prevent bleeding. Upon examination, I found a wound in the left side of the neck, made by a bowie knife passing through the sterno-cliedo-mastoid muscle splitting the common carotid artery an inch and a quarter. He was bleeding profusely. I laid him down on the floor, and by the assis-

tance of Dr. Robertson and Wood, attempted to compress the artery below and above. I enlarged the original wound, through the sterno-cliedo-mastoid muscle and other parts until the artery was reached, which was taken up and ligated below. Pressure was taken off from the upper end, when blood continued to flow. I then ligated it above, which stopped the flow entirely. He was taken to the hotel in an almost lifeless condition, having lost a large quantity of blood; but a reaction came, and during the night and next morning, the 16th, he was doing well, with the exception of cross paralysis, (to right side)—sensible but could not speak—tongue paralyzed—17th, doing well as could be excepted, and continued so till the 24th, when his pulse became irregular, and left eye began to fail. During the 25th, 26th, 27th, and 28th, did very well and spoke for the first time. 29th, the vision lost in left eye—the wound doing well. 30th, the upper ligature was removed, and in two or three hours I was sent for, and found hemorrhage (evidently from the sloughing artery above) was the cause. I thought he could not survive, but I had him propped up and pressure made upon the vessel, and in two or three hours reaction came, and by morning he was doing well. April 2d, the lower ligature was removed by Prof. Gregory, of St. Louis—no hemorrhage followed. He could now whisper, and had some appetite. His general health began to improve, and on the 20th he was able to walk about the room. He continued to improve, till final recovery, with the exception of the loss of the left eye, and paralysis of right hand and partial imbecility, which seems to be growing worse, and from present appearances there will be complete dementia in a short time.—*St. Louis Med. & Surg. Journal.*

HARELIP—NEW OPERATION.

Dr. Hammer desired to present to the notice of the St. Louis Medical Society a new method of operating in a case of harelip, which had been followed by the best results. He had mentioned, at a former meeting, that he was not satisfied with the means usually employed to correct the deformity; and had stated, that, should an opportunity present itself, he would institute another proceeding from which he expected the best results. Cases of simple harelip are successfully treated by the ordinary method, but in those which are double, and especially those accompanied by a double fissure, failure often follows the ordinary method of operating. The principal cause of failure is due to muscular action, especially to the action of the levator superiorus proprius, which exercises a continual strain upon the line of union. Any means by which this muscle shall be, or a time, debilitated or paralyzed, will and much to the full success of

the operation. Several methods have been recommended, but they have not borne out the hopes expected from them. The plan which he would detail, and from which he expected the best results, was intended to act upon the the muscles, paraliyzing them, and thus relieve the point of union from tension, and place the parts in the best condition for an accurate and firm union. It consisted in a suture additional to those ordinarily employed, and was prepared and used as follows: a largesized double ligature is passed entirely through the lip of one side, at a point above the angle of the mouth, and midway between the mouth and nose; the ligature is carried under the lip to a corresponding point on the other side of the face, where its exit is made; two small pieces of wood—portions of lead pencil would answer, covered by adhesive plaster—are placed at right angles with the line of the mouth, one on each side, and the ends of the ligature tied over each, forming a species of quilled suture. By this means, not only the action of the muscles may be controlled, but the whole mass of flesh can be drawn toward the central opening, thus lessening the space and relieving the central sutures of that undue tension, which is sometimes so great as to cause a separation of the united flaps and a failure of the operation. He had lately an opportunity to use the new method, and was glad to announce a complete success—the ligature having fulfilled even more than he had expected from it. The case upon which he had operated was a very peculiar one, the most deformed he had ever witnessed; the fissure being double, and the intercalarian bone not perpendicular, but inclined, and the alveolar process projecting. The middle pieces of bone, covered by a smal portion of skin, was removed three months ago; the skin retained, its edge pared, and attached by suture to one side. This healed well, and converted the external tissues from a double to a single fissure. Some days ago, the remaining portion of the operation was performed; the lips were first separated from the tissues beneath, the semi-circular cuts made, and five, thin, soft iron sutures introduced in the usual manner; the large quilled suture was then used, made of a narrow silk ribbon, doubled, and passed through the lip as described, the quills being attached to either end. Its application was attended with very satisfactory results; the parts could be more easily drawn together, and the central iron sutures more accurately adjusted; the margin of the flaps forming one vertical line; the lips could not move ontward owing to the pressure of the quills; tension, and consequently irritation, was removed from the point of expected union, and the parts being more closely united, union by the first intention more rapidly takes place. He had originally thought of using a wire suture for the quills, but apprehending that it night cut throught the lip in a transverse direc-

tion, he had substituted the silk ribbon, so as to relieve the part, in a measure, from the sharp pressure of the wire. He had at first intended to permit the quilled suture to remain *in situ* for three or four days, expecting that pressure exercised during this time would sufficiently paralyze the muscles so as to prevent their action for two or three days longer, but finding so little irritation produced by it, he did not remove it until the sixth day. After its removal, he found on the right side a minute fissure, three or four lines in length, which will heal and leave no mark, and on the left no noticeable cut was discovered. On the eighth day, the central wire sutures were removed, the union of the lip being *perfect*. This case was a very unfavourable one for any operation, yet he could truly say the operation was a perfect success, all his expectations being more than realized. His presumption as to the cause of failure in other cases was fully corroborated by the favourable termination of this case. All obstacles to quick union by the first intention are overcome, and although this is the first case operated on by the quilled suture, he believed, from the progress and result, as reported, that all cases of harelip, however great may be the deformity, can be treated successfully by the addition of this suture.

A week after the above report was made, the child was exhibited for the inspection of the Society. The result was a fine one, the union being firm and complete; the fissures in the bone had decreased already in width; and Dr. Hammer expressed the opinion that, by the time the child reached mature age, the deformity would not be greater than would have resulted had it been a case of simple harelip.—*Saint Louis Medical & Surgical Journal, May and June.*

A CASE OF SACCULATED ANEURISM: LIGATION OF THE COMMON CAROTID—DEATH FROM HÆMORRHAGE.

Under the care of Dr. Scriven of Long Branch, N. J.

A young man aged 27, returned from the army on the 14th of March, 1865, and immediately sickened with congestive fever. On the 22nd, eight days after, tumours appeared under each ear, and on the 28th were opened, and discharged pus freely. Simultaneously with these, abscesses appeared in other parts of the body, which were opened, discharged pus, and gave no further trouble. But on the 5th of April, the tumour under left ear began to increase, harden, and stopped discharging. April 8th pulsation was discovered in the tumour, which increased and became very distinct on the 10th. On the 13th, Dr. Scriven became fully satisfied as to the nature of the tumour. Thursday evening, I called with Dr. Scriven

to see the case. The tumour at that time was about the size of a hen's egg, situated over and posterior to the angle of the jaw. Dr. Scriven, upon examination, finding the skin to be very tense, was fearful of its sloughing, and thus bleeding the patient to death. Two surgeons were called to consider the propriety of performing the operation of ligating the common carotid artery. They opposed it for the time, but decided to meet on the following morning with others for reconsideration. Friday morning, 14th, at eleven o'clock, the case was consulted on, but fearing the patient was too much prostrated to undergo the operation, decided not to perform it. I remained with him during the night. At half-past twelve a.m. the tumour burst in two places, but I succeeded in arresting much flow of blood ; the loss being about one pint. This being the first blood he had lost, the effect on him was but slight. Saturday, 13th, Dr. Scriven called, and upon examination, decided, with the consent of the patient, to perform the operation. He willingly consented, and between one and two p.m. Dr. Scriven performed the operation with good success. The loss of blood did not exceed half a tea-cup full. The patient was in good spirits, and doing finely. Saturday night, ten hours after the operation was performed, the tumour (fed by a recurrent circulation from the communicating arteries in the skull) began to bleed furiously, and we did not succeed in arresting it until it had bled somewhere about one quart.

This, taking into consideration his weakness and the previous loss of blood, prostrated him, and he hung between life and death. But by a free of use stimultants and his excellent appetite, he gained strengh rapidly. That night rested well. Monday about the same. Tuesday, Dr. Scriven laid open the tumour. Within, the tumour was filled with coagulum ; and the sac being removed, the artery could be seen very distinctly. The patient remained about the same until Friday night, 21st, when, at one a.m., the external carotid leading to the tumour began to bleed freely, and there being no one present but the family, the hæmorrhage was not stopped until it had bled about one quart. The sac was so near the maxillary branch of the external carotid, that the coagulum formed being so short, the pressure of blood passing to this maxillary branch was so great as to expel it. That hæmorrhage in his emaciated condition was too great ; and he never recovered from the effect of the loss. It was with the utmost difficulty that life could be kept in him at the time, but his determination to live, and good courage, brought him through. Sunday, 23rd, he was very feeble, and his appetite, which until Friday had been excellent, and had been the principal means of keeping him alive, had failed to a certain degree. Sunday night, halfpast eight p.m., the

artery began to bleed, but it was arrested before it had discharged more than four ounces. But he had already lost so much by hæmorrhage that but a small additional loss of blood endangered his life; he became very much agitated, and for two hours he hung upon the brink of death.

During that night, Monday, and Monday night, he was very feeble, and at times fainty. His pulse was very weak, and respiration short and hurried. Tuesday morning, 25th, he had a fainting spell about ten a.m. and it lasted until eleven a.m. From eleven a.m. to four p.m. he laid in a state of coma, and died merely from exhaustion. This was a case of true aneurism, the internal coat of the artery being ruptured by the action of inflammation resulting from the abscess.—*Philadelphia Medical Reporter.*

RUPTURE OF THE AORTA FROM INJURY.

A man on lifting a heavy cask was struck by the latter, in its fall, on the upper part of the chest, and was instantly killed. On examination of the body it was found that the upper piece of the sternum had been broken through, and the blood was effused beneath. The heart was uninjured, as also was the aorta on its front aspect. Posteriorly, however, a transverse laceration was found, which half encircled the vessel, commencing at the under part of the arch, and proceeding upwards to the origin of the left carotid artery. Dr. Wilks said it might be a question whether the laceration was caused by a sudden contraction of the aorta, or whether it was caused by a simple bursting of the vessel from external pressure. He believed it arose from the last-mentioned cause; otherwise it might be difficult to show why a sudden and irregular contraction of the aorta should in one case cause a rupture of one of the valves, and in another a laceration of the aorta itself. Dr. Wilks said the case illustrated a fact which was constantly coming under notice—the injury of a deep seated part from falls and superficial blows. In the case of the heart, a difficulty had often arisen in the mind of the medical man, who could not explain how the organ could be ruptured on its posterior surface without any broken bone being present to account for the accident.

The President said that Dr. Quain had published three cases of rupture of the aortic valves, and he (the President) two cases. He had also collected others, in one of which only had the rupture been due to direct violence. He did not know any case in which the curtain of the valves had been torn down in the middle as in Dr. Wilks' specimen. Such cases were not common, and it was not easy to say how much disease and how much injury had to do with the rupture. Dr. Peacock related an instance in which rupture of the aorta occurred in a patient

who had been crushed by the weight of a heavy casting mould. The rupture was, he thought, due, not to direct injury, but to the sudden effort. The rupture was between the position of the ductis arteriosus and the origin of the left subclavian artery, ordinarily the narrowest part of the thoracic aorta.

Mr. Spencer Wells thought the medico-legal bearings of such cases ought to be considered. He related a case in point which occurred some years ago in his practice as a naval medical officer. One man struck another. The man struck ran to a place where water was to be had, and quickly died. An autopsy was made, and the cause of death was found to be a rupture of an aneurism of the aorta into the pericardium. The question as to whether the aggressor was to be punished for manslaughter, or simply for striking, depended entirely on the medical evidence. It was decided that there having been pre-existing disease, the punishment should be for a blow only. Probably in civil law the culprit would have been found guilty of manslaughter.

Dr. Sanderson said he thought it more likely that the rupture of the aorta occurred during diastole than during systole.—*Transactions of the London Pathological Society.*

EXTRACT FROM A CLINICAL LECTURE ON THE COMBINATION OF DISTAL WITH PROXIMAL COMPRESSION IN CERTAIN CASES OF ANEURISM.

By J. M. O'Farral, F.R.C.S., L.K.Q.C.P.I., M.R.I.A., Chief Surgeon to St. Vincent's Hospital.

I have long since been of opinion that compression of an artery on the distal side of an aneurismal sac should precede or accompany that on the cardiac side of the aneurism. I have often observed arrest of pulsation easily accomplished, attended at the same time with a flaccid state of the sac; but I have also remarked in such cases that the moment the pressure ceased the sac filled and throbbed as before. The formation of the coagulum is thus desirable as the first step to consolidation. A half empty sac is the ready recipient for the slightest thready current that can follow the cessation of the compressing force on the cardiac side. It therefore, appeared to me advisable to interrupt the current only when the sac was full of blood. These considerations, together with the knowledge of the fact that ligature of the artery on the distal side has sometimes cured an aneurism when the upper or cardiac portion of the vessel could not be reached, made me resolve to try this expedient whenever a a fair amount of pressure was not followed by success. From what

I have observed, I am inclined to think that cessation of pulse in a sac which suddenly diminishes in size and becomes flaccid is less likely to be followed by a permanent cure, whatever time may have been occupied in the compression; and that a sac which retains its volume, and is, moreover, full of coagulum, is less likely to be refilled, however short the duration of the compressing force.

When the supply is completely cut off by ligature of the trunk, I believe that the danger of relapse from refilling of the sac by collateral sources is more likely to occur when the sac collapses and becomes flaccid at the moment of deligation than when its dimensions are unchanged. This firmness of the parietes of the sac is always considered favourable to the success of the operation, as implying the presence of fibrinous deposits whether we attribute them to stasis of the blood or to inflammatory exudation, as suggested by the researches of that distinguished surgeon, the late Dr. Abraham Colles. I have no doubt, however, that whether a sac be filled by fibrinous deposits of some duration, or by coagulum recently formed, that a full sac is very influential in preventing the ingress of blood from a compressed artery above, or collateral branches from below; the compression below the sac need not, in some cases last more than a few minutes before the current above is stopped. If, on making the pressure above and arresting the pulsation the sac remains full, the object is attained, and time is merely required to allow the blood then liquid to coagulate in the sac. In other cases, it may be prudent to continue both compressions for a longer time. Three cases have already been treated on this plan with success. The first was published by me in Dublin Quarterly Journal for November, 1856.—*Dublin Medical Press.*

ON HYDROCELE OF THE HERNIAL SAC.

By M. Velpeau.

A tailor, aged twenty-four, entered one of M. Velpeau's wards, with a tumour on the left side of the scrotum, as large as the double fist, and situated below the external ring; it was soft, indolent, tense, fluctuating and irreducible. There was neither impulse on coughing nor transparency. It was prolonged by a pedicle, the size of the thumb, into the inguinal canal. The skin over the tumour was normal in appearance, and the testis was distinctly felt at the bottom of the scrotum. The man had worn a truss for several years for a hernia, which had never been completely reduced, a small swelling always remaining. Ten days prior to admission the truss had been broken, the tumour somewhat rapidly increasing in size, but without pain or inflammation. A portion of the

hernia only could be returned, and the man came to the hospital. M. Velpeau, much influenced by the free fluctuation present, came to the conclusion that this was an example of an old intestinal-omental hernia, in which the gut had been returned, leaving only omentum—an effusion of fluid having also taken place into the sac. Six days after admission the sac was punctured, and a reddish but perfectly limpid fluid having been discharged, the presence of omentum was ascertained. An iodine injection was then thrown in, and next day a pretty smart attack of inflammation occurred, accompanied by febrile action. This soon abated, and the patient went on very well, so that when he was discharged, three weeks after his admission, one side of the scrotum was scarcely larger than the other.

It was M. Velpeau who first conceived the idea of treating this form of hydrocele in the same way as hydrocele of the tunica vaginalis; of course, in such a case inflammatory action is more to be dreaded, owing to the intercommunication with the peritoneum; but M. Velpeau having found that iodine injections never give rise to purulent inflammation in closed cavities, determined to employ them in congenital hydrocele, taking care to compress the inguinal canal against the pubis. In the numerous cases of this kind in which he has employed these injections, he has never met with any accident, and he therefore naturally felt no hesitation in extending the practice to hydrocele of the hernial sac, in which the canal being plugged with omentum, the penetration of the iodine into the peritoneal cavity could scarcely occur. By this operation, also, conjoined with careful adjustment of a truss, the radical cure of the hernia may in some cases be effected.—*Brit. and For. Med.-Chir. Rev.*

ON THE TREATMENT AND CURE OF ABDOMINAL ANEURISM.

By Wm. Murray, M.D., M.R.C.P.Lond. Physician to the Dispensary, and Lecturer on Physiology in the College of Medicine, Newcastle-on-Tyne

When M. W. was brought to London last May and shown to the Medico-Chirurgical Society, several gentlemen desired me to give an account of the case as soon as all risk of a return of the disease had passed away. To those interested in the subject I need not give much of the past history of this case. That the man had suffered for some months from aneurism of the abdominal aorta was acknowledged by all who examined him privately, and by the meeting of the Northumberland and Durham Medical Society as expressed in very decided terms by the President at the meeting. That the aneurism was consolidated and that the aorta and its terminal branches had ceased to beat was acknowledged by all

who examined the patient at the meeting of the Medico Chirurgical Society. Since June the patient has enjoyed a very considerable share of health. He has gained flesh and strength so rapidly, indeed, that he has been regularly engaged as a fitter in Messrs Hawthorn's engine works, has worked generally twelve and sometimes fourteen hours a day, and has thereby been enabled to maintain his wife and his parents. His symptoms have been occasional loss of power in the legs and severe pain in the ham; and during the winter he has felt the cold very keenly, especially in his legs and feet. Once or twice he has had a severe pain in the back, which had readily yielded to treatment. He has been subject to severe cold and headache, and his digestive organs have been sluggish with a tendency to constipation. Once, and once only (in October), he has had an epileptic fit, which was severe, and left him very prostrate. Notwithstanding these elements, sometimes three or four weeks elapse during which he feels quite well.

The Aorta.—To this day I have not been able to discover the slightest pulsation in the aorta *below the tumour*, so that its occlusion may be considered an established fact. The femorals also are pulseless, and as far as I can make out there is no *large vessel* below the seat of the aneurism by which blood is circulating. The tumour has completely disappeared, and a dense resistance is all that can be felt over the seat of the aneurism; *above* this the aorta beats with a sharp forcible stroke.

So far, I think, it is clear, 1st, that this case of aneurism of the abdominal aorta has been cured by pressure; 2nd, that the aorta has been occluded without either temporary or permanent serious disorder; 3rd, that there must be a collateral system of vessels so complete as to carry on the circulation when the aorta is blocked. Since this case was brought forward others have been encouraged to adopt the treatment here employed. I had the pleasure of assisting Dr. Heath, of this town, in the treatment of a case of iliac aneurism by compressing the aorta, and the treatment has proved most successful. Since then, Dr. Mapother of Dublin, encouraged by the Newcastle cases, has achieved a brilliant success in a case of iliac aneurism treated in St. Vincent's Hospital. Each of these gentlemen will doubtless bring the particulars of his case fully before the profession. Meantime, I add their experience to mine in making the following remarks:—

First Proposition.—The introduction of chloroform in the treatment by compression in no way interferes with the coagulation of blood or the deposition of fibrin; by *it* this treatment is applicable to arteries in the most sensitive and delicate situations, and it may be used for several hours continuously without danger to the patient. Its use will add greatly to

the case with which the treatment can be carried out, and therefore to its efficacy. It ought to be used in treating aneurism in *other* parts, as well as those in the abdomen.

Second Proposition.—From these three cases it is evident that consolidation of fibrin alone does not cure the aneurism; *this is due mainly to coagulation of blood.* This is proved, 1st. by the clear indications in Dr. Heath's case and my own that the tumour ceases to beat and becomes solid within the space of *one hour* (see report of case) when once the conditions of coagulation are established; 2nd, by the rapid disappearance of the tumour after it becomes solid. In the Newcastle cases the dimunition in the size of tumours was a surprise to us all. The rapid formation and removal of the clot argues powerfully *for* its sanguineous and *against* its fibrinous nature.

Third Proposition.—It is now established that the cure of an aneurism by pressure need not be a tedious process lasting many hours and extending over many days. The question may be stated thus:—Are we to have cure by coagulation of blood in *five hours* by completely arresting the current through the aneurism, or cure by lamination of fibrin in *twenty-five days* by frequently and imperfectly arresting the circulation? The answer of of course depends upon the safety and efficacy of the *former* process. That it is as *safe* as the other I have no doubt, for in none of these cases has suppuration of the sac after treatment, or injury to the patient while being compressed, resulted. All that we can say with regard to the permanent efficacy of the treatment is, *that it has not failed in any one instance.*

Fourth Proposition—The experience derived from the treatment of the two cases of iliac confirms an opinion I had formed, that in all cases of aneurism of the larger arteries springing from the abdominal aorta it is best and perfectly safe to press on the aorta itself. (To command the channel of the aorta and to arrest its pulsation seems to me after numerous trials to be a most feasible operation.)

I need scarcely apologise for introducing this somewhat mechanical remedy, for I consider it acts according to known physiological laws, and operating through them it is a therapeutic agent. I will not here enter on the question as to whether a stationary mass or a feeble current of blood is most likely to coagulate; on its settlement hangs the adoption of distal as well as proximal pressure. I would say, however, that I have a case where an angurism seems to be developing very high in the epigastric region: and in this case when once the existing of the aneurism is certain, I shall apply a Signorini's tourniquet to the artery below the tumour, and by this *distal* pressure I hope to obtain a cure.

P.S.—I would compare the process of *coagulation* in an aneurism to those instances of crystallization which occur when the slightest disturbance of the conditions of solution determines the immediate solidification of dissolved matter, where a sudden movement, a rough surface, &c., are enough to induce the formation of crystals—*vice versa*, the completely arrested current seems to assume the solid form *at once and decidedly* as soon as the conditions of the solution of fibrin are disturbed: we are still uncertain as to the exact nature of those conditions, but we can disturb them in an aneurism by the compression treatment.—*Medical Times.*

LIGATION OF THE THE SUBCLAVIAN.

By CHARLES F. BULLEN, M.D., formerly Apothecary to the Montreal General Hospital, Acting Assistant Surgeon U. S. Army.

(Extracted from Dr. A. R. Becker's Fiske Fund Prize Essay on Gun-shot wounds.)

Adam Grignun, private, Co. D. 7th Conn. Vols., aged 21, was wounded before Petersburg June 9th, 1864, by a rifle-ball, which fractured the acromion end of the right clavicle, passed beneath the scapula and out below its lower border. On admision to the Hospital, three days after the injury, some fragments of bone were removed. The wound looked healthy, and continued discharging laudable pus and granulating till June 28th, 11 A.M., when secondary hæmorrhage occurred. He then lost about six ounces of blood before it was checked by pressure.

June 29, 10, A.M.—Hæmorrhage again occurred, more severely than before, losing from fourteen to sixteen ounces of blood. The cavity of the wound was by this time much enlarged. The hæmorrhage was again apparently checked by plugging the wound with lint saturated with perchloride of iron. But in two hours the whole of the tissues between the wound and the neck where engorged with blood, the swelling rapidly increasing, thus showing that he was still bleeding. After consultation, it was decided to stimulate freely and give narcotics to relieve pain, and let him remain till morning.

June 30th, 11, A.M., being in about the same condition—the tongue dry and glazed, pulse 120 and very weak, and with the engorgement gradually increasing—the subclavian was ligated successfully in the first part of its course. Coagula were then removed from the cavity of the wound, and it was syringed out with ice-water, no bleeding being apparent. Immediately after the operation he rallied; the tongue became moist; pulse at left wrist 110, at right wrist *none*. The temperature of both arms was the same, and continued so throughout.

July 1st, 10, A.M.—Left pulse 110, right barely perceptible. Patient

in good spirits ; takes nourishment freely, but complains of pain in swallowing. 10, P.M.—Left pulse 112, right same as in the morning. Ordered R. Liq. amon. acetat., 3 i.; tinct. aconit. M v.; to be taken every four hours.

2d.—Left pulse 110, right increasing a little in strength ; no pain in swallowing, and improving.

3d.—Left pulse 108, right same as yesterday.

4th—Left pulse 100, right same as yesterday ; takes nourishment freely, and both wounds looking healthy and well.

5th—Left pulse 96, right same as yesterday.

6th—Left pulse 90, right same as yesterday. Omit medicine.

7th—Left pulse 90, right same as yesterday. Complains of pain in the region of the heart, but no abnormal sounds heard.

8th—Left pulse 120, right same as before ; tongue dry and glazed. At 9, P.M., he had a rigor.

9th, 7, A.M.—A slight hæmorrhage from the point where the artery was ligated. The wound was plugged and pressure employed. At 10, A.M., the hæmorrhage recurred more severely than before. From this time until evening there were repeated hæmorrhages ; the patient gradually sank, and died at 8, P.M., remaining sensible to the last.

Autopsy.—Both the suprascapular and posterior scapular arteries were found to be in a sloughing condition, which was apparently the cause of the last hæmorrhages. The subclavian was ligated about half an inch from its origin. The ligature had come away, and the coats of the artery were ulcerated through. On the cardiac side a slight clot had formed, but on the distal side the clot was larger, firmer, and more perfectly organized.

This case is exceedingly interesting, both on account of the infrequency of the operation and because the man lived so long after its performance—nine days and eight hours; and at one time it really seemed as if he would recover.

PERFORATING ULCER OF THE STOMACH.

Dr. Hayden exhibited, before the Pathological Society of Dublin, a specimen of perforating ulcer of the stomach. The subject was a man, æt. 34, a patient in the Mater Misericordiæ Hospital. About two years ago he for the first time complained of uneasiness in the stomach, acid eructations, and uneasiness after taking food. These sensations occurred about two hours after meals, and generally ended in vomiting, which completely relieved him of the sensations. He went on in this state for about two years, during which time, however, the uneasiness

became converted into absolute pain. He was continually attacked with vomiting, and on three or four occasions threw up a quantity of dark grumous matter, evidently consisting of altered blood. He likewise passed a quantity of this matter from the bowels. He was admitted into the hospital on the 13th February. His appearance was then pale and anæmic; his pulse was quick, but in other respects normal. His tongue was clean. There was pain about two hours after taking food, whether liquid or solid, and acid eructations. The bowels were constipated and distended with flatus. There was no tenderness over the region of the stomach, and no evidence of disease of the organ could be detected by external examination. The pain after food extended to the lower dorsal spine; it was not of a very aggravated character, being very little more than uneasiness. On the morning subsequent to his admission, I found that during the night he had vomited a quantity of dark grumous matter, it was a good example of what is termed "coffee-grounds vomit;" it was manifestly altered blood, perhaps three or four ounces. I accordingly made up my mind that I had to deal with one of two things—either some form of latent aneurism finding an entrance into the stomach, or (still more probable) gastric ulcer. I treated the man on this assumption. On the following day, in my absence, he was attacked while at dinner with a severe excruciating pain in the abdomen. At four p. m., Dr. Cruise, who happened to be in the hospital at the time, saw him and prescribed for him, but he obtained very little relief. He took a dose or two of morphia, and continued to suffer till nine p.m., when he died exhausted. I should add, that though exceedingly anæmic, he was not at all wasted, and had a very good coating of flesh.

Post-mortem Examination.—On opening the abdomen we found a quantity of dark coffee-grounds matter diffused through the abdominal cavity. There was not a trace of inflammatory action—no peritonitis. On raising the liver from the surface of the stomach we found a good example of perforating ulcer, the aperture being exceedingly well defined, larger than a large goose quill, and perfectly circular. The stomach was much thickened in the neighbourhood of the opening. The edges of the aperture and portions of the surface in the vicinity were discoloured, manifestly with bile, the gall bladder lying immediately over the opening. In the neighbourhood of the perforation we found a quantity of exuded lymph in flakes on the surface of the stomach. On opening the stomach we found an ulcer in the immediate neighbourhood of the pylorus on the interior wall. On the inner surface this ulcer was about one inch in diameter. Immediately behind this, and upon the posterior wall of the stomach, we found a second ulcer of much greater magnitude, being 2½

inches in its long and about 1½ inches in its short diameter. The floor of this latter ulcer was formed by the adherent pancreas which was closely attached to the posterior wall of the stomach. Another ulcer, smaller than either of the former, was in the immediate neighbourhood of the cardiac opening of the stomach. This ulcer had not penetrated the walls of the stomach; it was about the size of a large pea, and its edges well defined. There was no evidence of inflammatory action around it; it was just as if the mucous membrane had been punched out. In front of the ulcer which passed through the walls of the stomach we, on closer examination, detected an old cicatrised ulcer, which penetrated only through the mucous membrane.

This case possesses interest in one or two points,—1st, as affording a satisfactory explanation of the absence of epigastric tenderness on pressure. The right lobe of the liver lay over the perforation, and hence there was no tenderness evinced on pressure, as the liver lay between the hand of the examiner and the diseased portion of the stomach. 2nd. The immediate cause of death was not exactly perforation, but the detachment of a very frail adhesion between the fundus of the gall bladder and the peritoneal surface of the stomach. On the surface of the gall bladder there was a layer of lymph corresponding to the portion of the stomach it lay in contact with. It is probable the lymph, which served as a bond of cohesion between the gall bladder and the stomach, was of a frail character, owing to it being mixed with bile by transudation from the gall bladder. The presence of this lymph in the immediate neighbourhood of the opening, and there only, further tends to confirm this view. 3rd. The case is of interest in respect to the condition of the patient, who, as already stated, was not at all emaciated, although the disease had lasted for two years. Of this we have an explanation in the fact that though the pyloric extremity was thus diseased, the remaining parts of the organ were in a tolerably healthy state, and in this way the man, who retained the food for some time, was capable of absorbing and appropriating various aliments at all periods since the commencement of his illness.—*Medical Press.*

Canada Medical Journal.

MONTREAL, JULY, 1865.

A LUNATIC ASYLUM.

We have not yet received a copy of the report of the Board of Inspectors of Asylums, Prisons, &c.; but, from what we have seen in the daily press, we are convinced that this report demonstrates most fully the necessity which exists of constructing a proper building in this section of the Province, for the care and treatment of those affected with mental diseases.

It appears to us, the Government are bound either to entertain the report and act upon it with promptitude, or they must, by continued neglect of the reiterated necessity, treat the report of their commissioners with silent contempt,—a course of action which, in any other country, would bring about the resignation of the entire body of those constituting the board.

The thrice told tale of over-crowding, which has been dinned into the governmental ears, by doctors, journalists, and the entire press, comes at last from those appointed by the executive to visit and report on the sanitary and other conditions of these institutions. We say, at last, for it does seem that the necessity has become too glaring to be over-looked, even by well-paid inspectors. We speak thus strongly because it will be found, on reference to the report for the year 1863, a controversy started between one of the Board of Inspectors and Dr. Workman of the Toronto Asylum on this very subject. The doctor states that his asylum is already too full, but, in spite of his remonstrance, we find Mr. Inspector Taché recommending the addition of fifty extra beds in the asylum, which, according to Dr. Workman, is, or was at the date of his letter, July 17, 1863, "full enough, and that the beds cannot be increased without risk to the health and lives of the present inmates." How the case stands at the present date in Toronto, we are unable to say, not having seen the report. But, in reference to the Beauport Asylum, it does appear that they are in a sad state for want of space, with the expectation, or rather the daily necessity, of extra room. But to go to figures. We

copy from the Toronto *Leader*. In May, 1862, the number of patients in the Beauport asylum was 418; in May, 1863, it was 444; in May, 1864, the number had increased to 534, and, in September of last year, it had reached 556. Let it be remembered that the building is considered full with 400 inmates. It is true that new wings have been added to the building; but in spite of increased accommodation the crowding was deemed by one of the commissioners, Mr. Hamilton, to be "prejudicial to health, both of mind and body, from the circumstance of so large a number being huddled together."

In the name of our common humanity, we would ask how long is this state of things to be allowed to contine. If the Government are unwilling to assume the responsibility, let them so state, and give to private individuals the power of erecting an asylum to be under Government inspection. We have good reason to know that offers have been made to the Government by private individuals to build an asylum and provide the necessary accommodation for this afflicted class of persons. The bare idea of endeavouring to adapt a rejected private residence, as was proposed, a short time since, in the house of the late Mr. Harwood, or the other schemes for acquiring college buildings which have not been found to answer the purpose for which they were intended, or even making use of the barracks at St. John's is absurd in the very last degree; it is a line of conduct which lays the members of our executive open to the suspicion of a question of their own sanity, and we doubt very much whether they do not themselves deserve to have issued a commission *de lunatico inquirendo* for the purpose of deliberating on their own state of mental calibre.

If reference be made to the imperial paper on "Colonial Hospitals and Lunatic Asylums," it will be found that in temperate climates 1,000 cubic feet of breathing space are necessary for each inmate of associated wards, and that in single rooms not less than 1,500 cubic feet are necessary. It appears that not over 300 cubic feet of breathing space are allotted to the inmates of the Beauport Asylum—a state of things which precludes all hope of beneficial results from treatment; in fact, it is little superior to the black hole at Calcutta, and we have little hesitation in believing it is very little better, and accompanied by almost an equal amount of death, though not half as merciful; for, in the one instance, the death was speedy and sure, in this it becomes a lingering but equally certain result.

We write thus urgently. It is a subject which has engrossed our attention for years; and, we would ask, is there not occasion for earnest and concentrated action? The fact is apparent to every one who chooses

to observe, for in our own streets may be daily seen many unfortunate wretches who should be taken care of in an asylum. But it is not done. And why? Because there is no asylum. With a population of 120,000 in our city, and a large populous surrounding county, there is no asylum. There is nothing but the cells of our common gaol, where these unfortunates would be far worse off than by allowing them to roam at large, with the possible alternative of their committing some desperate act for which the law cannot hold them accountable.

Since the above was in print, the tragedy enacted at St. Damase has occurred. We take the account from the daily papers. This lamentable affair proves more fully than words can express the culpable negligence of the Government in not providing means for the care of this afflicted class.

HORRIBLE MURDER AT ST. DAMASE.—On Friday last a dreadful tragedy was enacted at St. Damase, by Jean Baptiste Drolet, the unfortunate victim being his own mother. It appears that the murderer, about two o'clock in the afternoon, asked his mother for some milk. She sent him to where it was kept in an outhouse, but fearing that he might spill some of the cans, followed him. She had no sooner reached the place than her son seized an axe, and struck her a fearful blow on the head. The poor woman died an hour afterwards. The son was immediately arrested; an inquest was held on the body; and a verdict rendered that the deceased had come to her death by a blow inflicted by her son Jean Baptiste Drolet, and accusing him of wilful murder. It appears that the son is insane, and must have committed the act in one of his wilder moments. He has a wife and five children living. This sad affair has cast a gloom over the village St. Damase, where the deceased and her family were highly respected.

In a private letter received by Dr. F. W. Campbell, from Dr. William Frazer, lecturer on materia medica in the Carmichael School of Medicine, Dublin, and author of "Elements of Materia Medica, &c.," occurs the following passage, alluding to the several articles published in this journal, on the unfortunate case of accidental poisoning at Quebec some few months ago: "You had a curious discussion about a case of poisoning; your correspondents were a little bitter, but, in spite of all the evidence, I feel disposed to think that aconite was the tincture used." Dr. Frazer also remarks: "Much excitement has been caused by the reports of the Russian epidemic. At the College of Physicians, a few evenings since, Professor Houghton read a letter from one of the leading St. Petersburgh

professors, and, from it, it would seem that the epidemic is simply severe typhus, and relapsing fever, such as we had in Ireland in 1848, but that it was declining. He scouts the idea of a plague.

MEDICAL NEWS.

On the 10th of May Mr. Syme, for the second time, performed the formidable operation of excision of the tongue. The patient was a female about 56 years of age, who had been affected with malignant disease of the tongue for about two years, the affection implicating almost the whole organ, extending to within a short distance of the hyoid bone. Having made an incision in the median line from the lip downwards, Mr. Syme sawed through the lower jaw. The two portions being held apart, he readily and rapidly dissected out the whole tongue. Only two ligatures were required; and but little blood was lost. The operation lasted twenty minutes. The patient upon whom Mr. Syme operated some six months ago, is still well and there has not been any return of the disease. — Sir David Davies, M.D., died on the 10th of May. He was the domestic physician of His late Majesty King William IV and Queen Adelaide. — Dr. Clark, of Rockford, Illinois, recommends the internal administration of sulphur in large doses, frequently repeated, for the cure of indolent ulcers of long standing. One case took thirty grains five times a day, with most decided benefit. — Typhoid fever is the cause of the greatest number of deaths in the French army, being, for 1862, 185 per 10,000 of effective soldiers.

Mr. Spencer Wells objects to the operation of incision of the mouth and neck of the womb, as performed by Dr. Marion Sims. In his opinion, the use of the speculum is neither necessary nor desirable in the performance of the operation. "The operation can be much better done with a proper instrument in a second or two by the touch alone, than it can by a complex process of speculum, assistant, hook, scissors, knife, and plugs, as advised by Dr. Sims." Further, he says that there is no necessity to do more than cut through the mucous membrane and the innermost layer of muscular fibres. Mr. Wells holds it "to be not only unnecessary, but dangerous and injurious, to cut into the thick middle layer of muscular fibres." Mr. Wells says he has seen two fatal cases of periuterine abscess after free incision in the practice of others. He is confident that very "free incisions are as unnecessary as they are dangerous."—*Brit. Med. Jour.*