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Original Communications.

PIGMENTARY DEGENERATION OF THE RETINA
IN DEAF MUTES.

(Illustrated by Cases.)

BY W. TOBIN, F.R.C.S., HALIFAX, N.S.

(Read before the Canada Medical Association, at Kingston, September, 1883.)

The subject I have chosen for my paper is one possessing interest not only for the profession, but for the general public, illustrating as it does the sad results which follow a violation of the laws of nature by the intermarriage of near blood relations.

That such marriages have been punished in the offspring by idiocy, malformations and deafmutism you are all aware. That a form of blindness, due to retinal degeneration, complicates, at times, this last affliction, will be shown by the cases I bring before you.

Some months ago, a pupil from the Deaf and Dumb Asylum, in Halifax, was brought to me by one of the teachers, who stated that he had been trying to have him fitted with glasses as his sight had been becoming very defective. The optician had not been able to improve him.

He was a bright, healthy looking young man of 25 years. Externally, the eyes showed no trace of disease whatever, but, on testing him with de Wecker's types, at distance, I found vision reduced to an eighth. He could read Jaeger 14 at 10 inches. There was little accommodation. The pupil was slightly dilated and responded fully to light. With the ophthalmoscope I found the lens and vitreous transparent, but was struck by the

pale, patchy appearance of the fundus, which exhibited here and there solitary dots of pigment. I opened the pupil with atropine, and, on following the vessels, which were much diminished in size, towards the periphery, lost them in masses of black pigment, which formed a complete circle round the retina. This pigment was arranged in a lace like pattern. The whitish patches corresponded to denuded portions of the choroid, where the vessels were laid bare and seemed altered in structure. I had seen some similar cases at the clinique of my friend and teacher de Wecker in Paris, and recognized it as one of Pigmentary degeneration.

On inquiring into the history of the lad, I learned that his sight had been gradually failing for some time, that he could not read except in bright light, nor guide himself about with safety in the dusk of the evening. He was one of four deaf-mutes in a family of twelve children. They were all four losing their sight, and the eldest, a woman of 42, had already become blind. The other children were healthy. On expressing a wish to see more of the family, two others of the deaf-mutes came to see me. One was an intelligent young woman of 32, the other a fine lad of about 22 years. Both had been born deaf and dumb. I found them to be affected in the same way as the brother, but the disease was more advanced with them; and the girl had, in addition, in the other eye a post polar cataract. She had been a great reader. I did what I could for them—which unfortunately was not much—and saw no more of them till quite lately, when, in order to investigate their cases more fully, I followed them to their home in the country.

There I found the father still alive, an active and energetic old man of 75, who freely volunteered all the information required.

His parents, he stated, had lived to a great age, and had both been well formed and healthy. They had only taken to glasses late in life. They had had eleven children, all sound in mind and in body. Neither did their children's children (bar his own) suffer from nervous affections, deaf-mutism, or deformity—nor did he know of any such defect, in distant branches of

the family. His own sight had been bad from childhood, and he suffered much at school in consequence. At 20, the fault (a strong hypermetropia) was discovered and corrected with glasses. He had constantly worn them since then, but found of late years that he required them weaker than formerly. His eyes were very small (microphthalmos). His general health, he said, had always been good. He was well formed. His wife, the mother of the deaf-mutes and the eight other living children, had been a healthy woman herself, and came of healthy parents. She had died of heart disease at 50. She and her husband were near blood relations.

Of their twelve (12) children, five were girls, seven boys. The eldest, now a man of 47, was healthy. The second (Nancy), a woman of 42 years, was born deaf and dumb and was now blind into the bargain. The third, fourth and fifth (the two last twins) were healthy, though the twins required glasses. The sixth and seventh children were girls—one has imperfect sight, the other is asthmatic. The eighth (Jane), aged 32, was the one who had been to see me in Halifax. The ninth and tenth (boys) are healthy. The two last (Cotis and George) are the other deaf-mutes of the family. All the boys but the two last are earning a living in the States. Two of the girls are married and have raised healthy families. One other girl (unmarried) remains at home to look after the four unfortunates who require constant attention. I examined her eyes and found her slightly astigmatic. A. H. + 2 D. Corrected by C. + 2 D at 120. Otherwise her health is perfect.

I subjoin the cases of the four deaf-mutes more in detail.

Nancy, aged 42, of dark complexion, born deaf and dumb, and with bad sight. Had to use magnifying glasses at school, which the state of her eyes obliged her to leave at 22. Has not been able to read for the last ten (10) years, with any glasses. Cannot now follow the finger alphabet. Suffered from same symptoms in the other. Not examined further.

Jane, aged 32, dark complexion, dark hair, brown irides. Nervous temperament, very intelligent. Was born deaf and dumb. Passed six years in the Halifax Asylum. Sight failed

while there. Began with night blindness. Latterly vision has become very defective. Requires a strong magnifying glass to read (+14 to +16 D.) Cannot find her way about, out of doors, in the evening. When the snow is on the ground is apt to lose the path. Employs herself in the house in spinning. No external eye disease visible. Pupils large, not very sensitive to light. Vision for distance with de Wecker's type. Right and left eye 1-12th. Not improvable with glasses. Reads Jaeger 10 at 7 inches. Accommodation feeble.

Visual field, as tested by Landolt's perimeter, is reduced to a circle of ten degrees, round the fixation spot, for white, with smaller circle for red and green colours. Blue could not be distinguished.

Ophthalmoscopic appearances: The lens shows a stellate, post polar cataract, best seen by oblique light. The vitreous is free from opacities. The retina in the neighbourhood of the disk contains scattered masses of pigment, which abounds at the periphery. The retinal vessels are reduced in size. Their walls are thickened. There is no atrophy of the disk. I examined the throat and the ears, but except that the tympanic membrane was opaque found nothing unusual.

George P., the last brother similarly afflicted, is aged 22. He presents the same healthy appearance as the others. Has never suffered from any particular ailment. Was born deaf and dumb. Sight began to fail in childhood. Complained first of night blindness. He was, however, taught to read and write at the Asylum. Now can scarcely do either, even with glasses. Staggeres a good deal in his gait and knocks against objects in the room, when moving about. Works on the farm and does well enough in the daytime, but has to leave off before evening. As he cannot hear, and his visual field is much diminished, one has to be careful about going near him when chopping wood, thrashing, &c. Vision for distance in either eye equals 1-8th slightly improved by a + 2 D glass. Reads Jaeger 14 at 6 inches with difficulty. Takes a + 6 D for reading and requires a bright light and his back to it. Little accommodation. Pupil dilated and inactive. No external signs of disease. Media

transparent. The retina presents same appearances as in sister's and brothers' cases. Pigment more abundant. No atrophy of disk, vessels reduced to threads and showing signs of sclerosis, membrana tympani indrawn and opaque. Throat slightly granular, has been suffering from catarrh.

His visual field is reduced to 15 degrees above, 15 to the nasal side; 10 degrees below and same to the temporal side. There is a slight difference between the field in either eye. He has no loss of colour, having a field of 10 degrees for light green (about same as white), 8 degrees for red, and 5 for blue. The last colour he found it hard to distinguish.

The other brother's case has been already gone into. I found his visual field also much contracted. His color sense was unaffected. There were no signs of disease in ears or throat.

In all those cases, torpidity of the retina, which requires the brightest light to stimulate it, and a form of night blindness, which makes it impossible for the patient to read or work or get about in the evening, are the first symptoms, and may be the only ones for years.

A gradual contraction of the visual field follows, limiting the patient's vision to one object at a time, central vision remaining unaffected, till the disease, in a gradually contracting circle, reaches the macula, when sight is abolished for ever. The patient may be able to read the finest print up to the last. This was not so, however, in my cases.

Pigmentary deposits in the retina were first described by Langenbeck in 1836. Ammon followed in '38 with two cases. Donders and Von Grafe gave us the characteristic ophthalmoscopic appearances, and traced the connection of the disease with deaf-mutism and consanguine marriages. Donders in 1857 published an anatomical study of the disease to which he prefixed its present name—Pigmentary retinitis. To Leber, Broussais and Pope, so late as 1868, we owe more of our knowledge of the subject.

Pigmentary retinitis is described as a very slowly progressive, symmetrical disease, leading to atrophy of the retina, with great

contraction of its vessels and accompanied by the collection of black pigment in its layers and around the blood vessels (Nettleship). It generally begins in childhood—sometimes it has gone through all its phases in utero and the child is born blind—rarely it appears in advanced life—when its progress is more rapid (de Wecker). The disease is strongly hereditary (Von Grafe), affects the boys of a family more than the girls—not so in the present instance—coincides sometimes with deaf-mutism or idiocy (Jaeger) and appears generally in children who are the issue of consanguine marriages (in 40 to 50 per cent according to Zubrich, in 25 per cent only according to de Wecker) and appears in others who are affected by congenital syphilis (Galezowski). Some of its subjects are healthy both mentally and physically (as in my cases); others are ill-formed and intellectually defective. Errors of refraction may complicate the disease, usually Hypermetropia. It is always binocular and symmetrical in progress. “The typical cases are congenital, but this variety, which follows a slow course, ending about 40 in complete blindness, is not accompanied by arrest of development, by deformities, or defective intelligence” (de Wecker.)

The fundamental characteristic of the disease consists, according to Jaeger and de Wecker, in a slow and progressive proliferation of the cellular element of the external retinal layers and their transformation into a dense tissue, accompanied by a hypergenesis of the cells of the epithelial layer, which penetrate the degenerated retina. The three changes which that membrane undergoes are:—1st, a softening of the external layer, accompanied by proliferation of the epithelial cells; 2nd, a hyperplasia of the cellular tissue contained in the external granular layer, involving the destruction of the rods and cones; 3rd, a sclerosis of the retinal vessels, leading to a thickening of their walls, with a decrease in the column of blood. This want of blood, added to the destruction of the rod and cone layer, explains the torpidity of the retina, which precedes the pigmentation. The vitreous and choroid may be unaffected, though the stroma of the latter is laid bare and its vessels may undergo sclerosis.

“ We remark, then, in this affection, a progressive atrophy of the retina, which advances from periphery to centre, attacking first the sensorial layers and ending by destroying the conductory elements of the optic nerve itself” (de Wecker, *Therapeutique oculaire*.)

The characteristic ophthalmoscopic image may not be present in the beginning. The primary lesion is the sclerosing degeneration, which precedes in the retina the migration of pigment and which appears first where the nervous tissue is least abundant, namely, at the periphery. “ The quantity of pigment varies with the date of the affection, and, in the beginning, in young subjects, when the cellular tissue which takes the place of the nervous elements has not yet undergone a sufficiently defined retraction, we may find no pigment whatever.

“ The pigmentary degeneration begins by the apparition in the most peripheric portion of the retina of small clots of pigment, presenting a star like pattern, which has led them to be compared to the lacunæ in bone, several of these coalesce, throwing out branches to similar spots in their neighborhood. The walls of the vessels form an attraction for the pigment which accompanies their course in places, in others completely obscures them. It is found most plentifully between the forks of their branches. As the disease progresses, the pigment spreads over the whole fundus, like the links of a coat of mail, from circumference to centre, till the macula is finally invaded. In the later stages a yellowish-white atrophy of the disk may be noted. The vessels are diminished to threads or disappear altogether at a distance from their origin. The tenuity of the vessels is due to the sclerosis which has attacked their walls. A double white line enclosing a thin column of blood is all we can see of the arteries. The vessels of the choroid are laid bare by the peeling of the epithelial layer. They may also suffer from sclerosis. Post polar cataract may be present, but remains stationary for years and is confined to the cortical substance. Vitreous opacities are uncommon.”

Such, gentlemen, are the ophthalmoscopic appearances of this disease, as described by de Wecker, in his “ ophthalmoscopic

clinique," a description which tallies perfectly with that presented by the case I have brought before you.

Since writing the above I have come across another instance of this affection, in a woman from the Poor House, Catherine B., aged 50, who came to me complaining of gradual loss of vision. She was born in Ireland, of healthy parents. Her brothers and sisters (5) were also healthy. She had never suffered from any particular ailment herself till sight began to fail which is nine years ago. She was neither deaf nor dumb. Her parents were in no way related. Eight years ago she first found trouble in reading. Then flashes of light and flying plays of colour would appear before her eyes. Next she could not work in the evening: within the past four years she has not been able to mount the Poor House stairs after night fall. Sight has gone more quickly since she got a fright at the great fire there last November.

V. R.=1-20. Cannot read largest type. Counts fingers.

V. L.=1-12. Reads de Wecker 8 at 10 inches. In the right eye, visual field is reduced to a circle of 5 degrees and she cannot distinguish colors. In the left eye the field is somewhat larger but she takes blue for red and green for white. With the ophthalmoscope, the disk in both eyes looks indistinct and hazy. There is an abundance of pigment, scattered in large patches all over the fundus; in the right eye the disease has encroached on the macula region. Large patches of choroidal atrophy in both eyes. Choroidal vessels visible as white ribbons containing no blood. Retinal vessels very small. The walls hyaline, thickened, containing a thin stream of blood. The disk in the right eye very pale. Hearing and speech perfect.

This case is interesting as showing that the disease may exist without any consanguinity between the parents. I have seen it in a child of ten years under similar circumstances (not a deaf-mute either). In the next case it appeared late in life, and in a woman. De Wecker states he has rarely seen the disease in a female. Again there is a want of symmetry between the two eyes, vision is much more defective in one than in the other. There was no change in the lens in either eye, though the last stage almost had been reached by the right one.

Treatment in all these cases is hopeless. Generous diet, attention to general health, and the use of occasional hypodermic injections of strychnine, is all that can be recommended. Any error of refraction should be corrected with suitable glasses and if there should be (as there rarely is) an over-sensitiveness of the retina, colored glasses or a shade may be ordered.

Unfortunately these cases, in spite of all treatment, tend slowly towards hopeless blindness.

SUCCESSIVE DROPSIES OF THE AMNION ALWAYS SPECIFIC.

BY JAMES DORLAND, M.D., MILWAUKEE, WIS.

(Read before the Canada Medical Association, at Kingston, September, 1883.)

CASE I.—Mrs. D., aged 30, full habit of body, and apparently healthy. Was called to attend her for the first time, in her fifth confinement, July 16th, 1880. Found the os fully dilated and membranes very tense and bulging with fluid. Externally, found the abdomen high up, interfering somewhat with respiration, the skin very tight, and palpation giving evidence of a large amount of fluid. Ruptured the membranes, and it was followed by a great gush of water, then the child, and another large quantity of fluid. The amount was between eight and ten quarts, but certainly not less than the former. The foetus proved to be about seven months old, and had been dead about 24 hours. She said it was not an unusual amount of water, as in all her previous confinements she had about the same quantity. Had been married to a sailor eight years. Could give no reason why so much water would form. The other four children were still-born at four, six and seven months. Had been treated for it at various lake ports, but derived no benefit. Knowing the habits of sailors, I began to look about for a cause, but both of them denied ever having any specific disease. I was not fully convinced, and determined, when she again became pregnant, to put her on specific treatment.

About the 1st of January, 1881, finding her in that condition, I began treatment, and continued it thoroughly until she had passed the seventh month and was well on towards the eighth.

At the ninth month, September 3rd, I delivered her of a 13 lb. girl, which was perfectly healthy and is alive to-day, and has shown no traces whatever of syphilis. Did not allow the mother to nurse it. There was no dropsy. She again became pregnant, and, satisfied that if she were to blame, the previous vigorous treatment would be sufficient, only gave her a couple of bottles of medicine.

Aug. 3rd, 1882.—I delivered her of an 11 lb. boy, healthy, and well developed. It has since died, but from no disease connected with syphilis. There was a slight increase of fluid over the former, not amounting to dropsy.

She became pregnant on the following November, but I did not see her until I was called, August 5th, 1883, to attend her. She complained of not feeling as well as with the two former, and had felt no life for two days. Upon examination, found dropsy of the amnion, and thought the child would be dead, as I was not certain I could detect the foetal bruit. About five quarts of water came away, and she was delivered of an 8 lb. girl, which presented marks of syphilis on its hands, feet, and several portions of the body. She now admitted having had some sores, but stated they were after marriage. The child was alive, and was at once put on specific treatment.

CASE II.—Mrs. P., aged 25, of short stature, but well developed; married to her second husband; the mother of one boy by her first, aged 15, strong and healthy. Had six children by her present husband, all born dead, or died shortly after, within three or four weeks. I saw the last one, November 1st, 1880; it was about three weeks old, and had well marked syphilis, and died about three days after. Both parents strenuously denied ever having had any specific disease, but the previous history of the mother, and the loose character of the husband, led me to suspect him as the culprit. With all her children by the last husband, there had been an abundance of water, and the midwife said some of them had been drowned. When she again became pregnant, I put her on specific treatment, and delivered her (Oct. 4th, 1881) of a 9 lb. girl, and at full time, alive, with no traces of syphilis, and about the ordinary

quantity of liquor amnii. Did not allow her to suckle it. The child is still alive, and healthy.

A short time after, she became pregnant, and, not believing what was told her, refused to take specific treatment. When labor came on, was sent for; found the os fully dilated, a large bag of water protruding into the vagina, and the abdomen very tense. Ruptured the membranes, and succeeded in collecting 10 quarts of water. The child was dead. The delivery was August 10th, 1882. In November she again became pregnant, and took medicine as directed, and on 11th August, 1883, I delivered her of a fine healthy child, without any dropsy. She had felt much better than when carrying her previous child.

CASE III.—Mrs. H., aged 25, spare habit of body, but wiry, the mother of four children. The two first only lived a few weeks after birth. I did not attend her with either of them. Had treated the father for syphilis. She stated that when they were born a great quantity of water came away; supposed that was natural, until after her next was born. The midwife stated there were about six or seven quarts of fluid. With her third and fourth I attended her, and kept her on specific treatment during gestation. They were both fine healthy children, but one of them has since died from convulsions. At neither of her last confinements was there any undue collection of fluid. The father had also, in the meantime, taken a further specific course.

CASE IV.—Mrs. H., aged 17, married at 14, of short stature, but strong and healthy; the mother of three children, two of them being now dead. Had treated her husband for syphilis before marriage, but he did not take a very thorough course. When pregnant with her first child, advised specific treatment, but they would not listen to it.

Aug. 22nd, 1881.—Delivered her of a seven months' foetus, which was dead. The cord was only 8 inches long. On rupturing the membranes, about seven quarts of water came away. The child had only been dead a few hours, probably since she had a chill. She soon became pregnant again, but still persisted in not taking any medicine.

July 16th, 1882.—Was called; found the membranes ruptured and about half the liquor amnii in a pail. It measured six quarts. When the water flowed freely, she would get up and go to the pail, and wait until the pain was over. I do not think it any exaggeration to state that as much was lost on the bed-clothes and floor. When the child was born, about another quart came away, making 12 or 13 quarts altogether. Contrary to my expectations, the child was alive and lived two weeks before death, presenting the characteristic old man appearance of syphilis.

When she again became pregnant, consented to take medicine, and it was pushed thoroughly. About ten days before labor she began to enlarge quite fast, and upon examination, found more fluid than normal. Had stopped all treatment for about three weeks previous; now, however, I again began giving Potassium Iodide 5i per day, which acted on the bowels quite freely. I continued it until the birth of the child. About the fifth day after taking the Pot. Iod. the movements of the child became stronger, and the tenseness gave way.

July 6th, 1883.—I delivered her of a 10 lb. boy, with only slight traces of syphilis, and no undue amount of fluid.

CASE V.—Mrs. S., aged 41, short and robust, the mother of nine children. The first was born in Scotland, the second in England, five in Greece, the eighth in England, and the ninth in the United States. Generally noticed that she began to enlarge quite rapidly a fortnight or six weeks before the birth of her children. First child still-born, with an immense quantity of fluid; fifth, a large amount, but the child was alive, and died two weeks after; eighth child only lived 20 minutes, and she thought the death was due to too much fluid. I was called to attend her with the ninth; found the os fully dilated. I ruptured the membranes and collected six quarts of water; not more than a pint escaped. The child, a male, weighed 13 lbs., and died 15 minutes after birth. The cord was 12 inches long and fully an inch in diameter. She was confined March 23rd, 1883, Could get no specific history from either parent.

CASE VI.—Mrs. W., aged 38, spare habit of body, the mother of five healthy children by her first husband. Her second one had three by his first wife, all healthy. He contracted syphilis and gave it to this one. They paid very little attention to medicines prescribed; only when some external manifestations were present, and painful, they would use some local application until relieved. During this time, which was in 1881, she became pregnant, and, contrary to advice, stopped treatment. At the eighth month she had some severe pains, and sent for me. Upon examination, found the os dilated so as to admit the tip of the finger. The membranes were as tense as they should be during a severe pain. A great change had taken place in her abdomen, it being enormously distended. It was symmetrical, and pushed up the diaphragm so that respiration was very much interfered with. Expression anxious. Said the skin felt as though it would burst. Gave her an anodyne. The following day she had a chill, and four days after, labor came on. I arrived a few minutes after the membranes had ruptured, and found the bedding and carpet saturated with water. The patient was in an anxious frame of mind; felt sure death was approaching, as, to use her own words, she had collapsed. Said she had passed fully 24 quarts of water, a great gush following and during a second pain. I soon delivered her of a still-born child. At the lowest calculation, there could not have been less than 20 quarts, and I firmly believe, could it have been collected, it would have reached 30, for I have never seen such a flood in a parturient chamber.

Remarks.

CASE I.—This patient, after having five still-births, all with dropsy, was able to have, after one thorough course, three children in succession, all born alive—the two first without dropsy, and without any sign of syphilis; the last with dropsy and a showing of syphilis, but still alive, and with fair prospects of living. But the last case also shows that some of the effect produced by specific treatment is beginning to wear off. After this last one, I received my first intimation from her that she had ever been diseased, but I had long since found out I was right from a sister

of hers who came to the city later and entered a house of prostitution.

CASE II.—This is also a very valuable one, for here we have six cases of dropsy following in succession, the seventh, under specific treatment, being born without, and perfect in every respect, and free so far from any sign of syphilis. The next, or eighth child, with no treatment whatever, again born with dropsy, and dead. The ninth, after quite a thorough course, was also born alive, and without dropsy or any signs of syphilis. The husband proved to be the guilty party in this case, and probably that was the reason the first thorough treatment was not sufficient to tide the next one over till full time.

CASE III.—Although I did not see the two children that were born with dropsy of the amnion, the report is perfectly reliable, and I think to the specific course of treatment can be attributed the next two natural births. The father had also, after the birth of the second child, taken further treatment.

CASE IV.—Here we had two cases of dropsy, the husband known to be syphilitic; the third, after the mother had been treated, born alive and with no dropsy, but still with slight traces of syphilis on the palms of the hands and soles of the feet. The father in this case had a very severe attack, and took but little medicine, so that his blood is in a much worse state than any of the others. It is to that I assign the reason of the thorough treatment of the mother not removing every trace of syphilis from the child.

CASE V.—Although not mentioned in my report, all the nine children that were born had dropsy of the amnion, the ones I specified being the most excessive. Although no history from father or mother that would point to syphilis, the condition of the living children, their stunted growth, saw-edged teeth, general appearance, and the illness of one of them, for which no cause was apparent, and which had not yielded to other forms of treatment, and which potassium iodide readily cured, leave scarcely a doubt in my mind but that the father or mother has had syphilis, or is the victim of an inherited taint.

CASE VI.—Although no direct bearing on successive cases, the fact that there could be no doubt as to the cause of the dropsy and the excessive amount of fluid led me to report the case.

These are the facts I have to lay before you in support of my theory that successive dropsies of the amnion are always specific; facts that cannot be obtained from our lying-in hospitals, but from private practice, where attendance on a family has extended over a number of years, and where you have the time and patience to ferret out the cause of diseases from many who do not care to have you know their previous misfortunes, or do not inform you for fear of further complications. In hospitals we seldom see the same patient twice, hence the conclusions arrived at there would be of no use either for or against this theory. That syphilis has caused it, has more than once been advanced, but generally denied, and I think the Germans are the only ones who put much faith in it. That syphilitic children are born without dropsy often happens, for no doubt most of you have seen such cases. These cases of dropsy could not have arisen from any other cause, for there is no history in any of the cases of any inflammation of the amnion, for not one of them suffered from the least bit of pain, but only discomfort, after the fluid had accumulated. Very few of them ever had a chill, and in those the dropsy was present before that time, and the chill only seemed to mark the death of the infant, and not always that. None of them ever had any general anasarca during gestation, and their kidneys always seemed to be fairly active. It could not have been disease of the heart and kidneys of the infant, because some of them were born at such an age, as the one at four months, with about four quarts of fluid, that it would be an utter impossibility; besides, many of them were born alive, and are still alive, and, in most of the cases, even at full term, the dropsy came up in such a short time that the kidneys of no infant could have secreted the amount. I was sorry that I could obtain no post-mortems of the cases I attended, but even had I found hypertrophy of the heart or kidneys, I should have placed no stress upon it, for I do not believe it could cause it, nor that

we have any facts that point in that direction. The death of the foetus and osmosis could not have produced it, for the same reason stated above, that many of them were alive, and lived some time after birth. It has seemed to me that it would be impossible to have a dropsy except from systemic infection producing changes in the amnion, or following a debilitating disease, like latent pleurisy often does; but that all these cases were in good health shows that it was not due to the latter, but to a poison which can lurk for years in the system, and, as far as outward signs go, give no evidence of its presence. Such a poison is syphilis, and I believe that if not the only cause, it is the one *par excellence*, and the only cause of successive cases.

Cases 1 and 2 would, I think, have been sufficient for my purpose, but the others were added because in unity there is strength. These cases all happened in mothers who spent many hours in grief because of the loss of their children and their inability to have them born alive; and if to any such among your patients relief is brought, I shall feel amply repaid.

OUR LONDON LETTER.

(From our Special Correspondent.)

OPENING OF THE SCHOOLS—LISTERISM IN LONDON—GASTROSTOMY.

Although barely a fortnight has passed since the several London Medical Schools were opened for the session of 1883-4, everything seems already to be running at full speed. There is such an amount of rivalry existing between the large schools and such a scramble for existence in the case of the smaller ones, that the work of teaching is kept up to high pressure mark for at least nine months in the year. There are now so many schools having men attached to them equal in ability and reputation, that students and their friends often find it no easy matter to make a choice. The tendency is to crowd to the schools attached to the larger hospitals, the general impression being, of course, that the more patients the student sees the more he is learning. I think it will be found, however, that in the smaller hospitals, such as King's College, University College, and St.

Mary's, for instance, where no surgeon or physician has more than thirty beds, the material is much better worked up, and the student really benefits more.

Many of the schools opened with the old fashioned "introductory," while others began work quietly on the first of October. The Guy's men held a *conversazione* on that day, while the St. Mary's men had their annual dinner of "students past and present." This latter proved to be a very pleasant gathering. Some two hundred sat down, the present students being represented almost entirely by those of the final year. Men came from all parts of Great Britain and two or three from France in order to meet old mates and compare notes. By the way, St. Mary's is rapidly coming to the front as a school of medicine. The Faculty have just opened a new building immediately in rear of the hospital, their old quarters having become too small to accommodate the increased number of students. Mr. Fields, lecturer on aural surgery, is their newly elected Dean. He has always evinced a deep interest in the welfare of the school, and altogether the appointment is considered an admirable one. He is what one of the speakers at the dinner called "an honest specialist."

The London Hospital Medical School was opened with an address by Professor Huxley, who also distributed the prizes to the successful students and nurses of the past session. The learned professor chose for his subject the "intervention of the State in the affairs of the medical profession." The address was evidently well thought out, although disappointing in some regards. He is apparently a great conservative in the matter of medical legislation, and believes that the Act, which came into operation in this country nearly thirty years ago, should, with very slight modifications, still be made to meet all the requirements of the present day. He contended further that the State should take no part in protecting the general public against incompetent persons, but that "every one should choose his own way to be killed." Fortunately he modified this extraordinary statement later on by suggesting, that in the event of death, none but medical experts should be allowed to give evidence.

In another part of his address the professor made certain suggestions regarding the course of medical study, and he was listened to with marked attention. For instance, he advocated the foundation of two or three central institutions for the teaching of anatomy, physiology, and chemistry only, the teachers to be specialists in these subjects. From these "institutes of medicine," after a year or two, the students would go to the various hospitals to get a practical acquaintance with the phenomena of disease. While much may be said in favor of such a scheme, the question arises, is it wise to place medical students, for so long a time, under the guidance of specialized physiologists and chemists? The latter are not likely to know the real wants of the medical student, but would be apt to spend much valuable time on the study of subjects having little, if any, direct bearing on practical medicine.

It is very noticeable that many of the older men, whose names with us are veritable household words, are, from various causes, rapidly withdrawing from the teaching arena of London. Some have the good excuse of advanced years; others are too much absorbed making hay now that their sun (obscured, perhaps, for many long years) has at last shone out; whilst a third class have been obliged to retire in order to conform with an absurd rule which shelves a man after twenty years' service. One of the victims of the heinous law just referred to is no other than that able surgeon and pathologist—that great all-round man, as his friends like to call him—Mr. Jonathan Hutchinson. I am wrong in calling him a victim, because he has well earned the rest thus given him, and will doubtless profit by it as far as health is concerned. But it is the London Hospital itself and its school which will suffer, because his place cannot be filled for years, if indeed they ever raise a man with such professional instinct and remarkable teaching qualities as Mr. Hutchinson possesses. In order that his name may still be retained among the list of teachers, the Faculty have made him Emeritus Lecturer on Surgery, and he has consented to deliver one lecture a month during this session. As a consequence of all this, the younger men attached to the various hos-

pitals, chiefly of the rank of assistant-surgeon, do the great bulk of the teaching. This is right and proper, and for didactic teaching nothing could be more suitable, but one would like to see opened more frequently those great store-houses of clinical knowledge which must and do exist in this city. I have been disappointed already a score of times in going round hospital wards with some of the ablest men here, to find how little they utilized, for teaching purposes, the vast amount of material at their disposal. Fortunately there are two or three marked exceptions to this rule, but often these are not appreciated to the extent one would like to see, at least judging from the number of students attending their respective classes. One of these exceptions, I cannot refrain from mentioning, is Mr. Lister, who is acknowledged on all sides to be a most painstaking clinical teacher.

Speaking of Mr. Lister, there are many who think that he made a great mistake in coming to London; not on his own account of course, because he has as large a *clientele* here as he ever had in Edinburgh; and besides he is quite independent of practice. I refer to his position as a teacher and hospital surgeon. In Edinburgh he yearly infused into the minds of at least three hundred medical students those great surgical principles of which he is master, and sent scores away every year to all parts of the earth to preach the gospel of Listerism; now he influences a mere corporal's guard. I have been agreeably surprised, however, to find that the majority of London surgeons have adopted Lister's method. In the London Hospital Mr. Cooper is a great enthusiast in that direction, and has succeeded in converting nearly all his colleagues to his belief. In St. Mary's Hospital, all the surgeons but one operate under the spray and use the gauze dressings. In St. Thomas', Mr. Croft and Mr. Sydney Jones—the only men there whose operations I have yet witnessed—carry out Mr. Lister's directions almost to the letter. In fact in no hospital in London, have I failed to find some evidence of Lister's teaching, so that while his plan may not be carried out in all its details, the main principles are there, and require time and experience only for their complete development.

The case which has interested me most since my arrival in London, is that of a woman aged about sixty, on whom the operation of *gastrostomy* was performed by Mr. Pepper, of St. Mary's Hospital. The patient had had symptoms of obstruction of the œsophagus for some months, but of late this had become so complete that no bougie, however small, could be made to pass. She was much emaciated, but not cachectic looking, although malignant disease was diagnosed. The operation was divided into two stages: the first consisted in making a straight incision from the point of the xiphoid cartilage downwards and slightly to the left, for a distance of about two and a half inches. The aponeurosis and muscles having been divided on a director, and all bleeding arrested, the peritoneum was opened and the stomach sought for. The left lobe of the liver was seen first to present in the wound, but soon the stomach was recognised and drawn forwards. Neither the omentum nor transverse colon interfered with the finding of the stomach as they sometimes do. The stomach was then stitched all round to the edges of the wound and peritoneum, care being taken to pass the needle through the peritoneal and muscular coats. The kind of suture used throughout was carbolyzed silk. The operation was performed under the strictest antiseptic precautions, a heavy spray of one to forty carbolic acid being used throughout. The wound was dressed with carbolyzed gauze. The patient was sustained by nutritive enemata and progressed without a single bad symptom. On the eighth day a small opening that would admit a number twelve catheter was made into the stomach, and when I heard of the case two days ago she was still doing well.

The operation of *gastrostomy* is now recognized as a perfectly justifiable procedure in surgery, especially in cases of cicatricial contraction, syphilitic ulceration, and early cancer. Even in advanced cases of cancer it puts the œsophagus at rest, and relieves the dreadful pangs of hunger and thirst which are so often present. Mr. Sydney Jones has, I understand, operated in three cases recently, but was unfortunate in losing two of them from peritonitis, while the third died on the tenth day from exhaustion.

T.G.R.

LEPROSY IN NEW BRUNSWICK.

(Continued.)

By J. E. GRAHAM, M.D., TORONTO.

The following records of a few families living in Tracadie have been obtained from residents of the parish. They are, I think, correct, as far as they go, but, of course, more or less incomplete. They may, however, be of some assistance to those who wish to further study the disease as it exists in that locality. The dates are given in but a few instances, as they could only be obtained from the church register, and the writer had not time to consult these documents to any great extent. The registers, however, have been very well kept, and it would be possible, through them, to trace the disease in the several families of the neighborhood. Two points are clearly shown in these records—1st, That the disease frequently skips over a generation; this appears to be the rule rather than the exception. 2nd, That the disease appeared at about the same time in members of several families who were not related to one another. It would be hard to account for this fact on any other theory than that of contagion:—

Joseph Benoit, leprosy, married Ursule Landry, leprosy.	None had leprosy.	Ancel Benoit. Germain Benoit, married Charlotte Comeau, daughter of a Goutreau; two of the children died of leprosy. Ellen Benoit.
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Firmin Benoit, married Isabella Landry, leprosy.	None had leprosy.	Dominick Benoit, married a McGrath; two children died of leprosy. Lawrence Benoit. Vezina Benoit, Married McGrath. McLoughlin. Alex Comeau.
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Victorin Landry, leprosy, married Victor Savoy.	One child died of leprosy.
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Ursule and Isabella Landry were the two first victims. The Benois apparently caught the disease from their wives, as there is no previous history of leprosy in the Benoit family.

THE SONIER FAMILY.

First Generation.

Joseph Sonier came to Tracadie or Westmoreland in 1790.

Peter Sonier.
Alexis Sonier.
Mrs. Finn.
Ann Sonier.
Mrs. Savoy.
Rosalie Sonier.
Mrs. John B. Arsenau.
Isabel Sonier.
Bridget Sonier.
Mrs. Mary Gould.
Nasturia Sonier.
Florazine Sonier.
Mrs. Capt. Gould.
Moses Nowlan.

No leprosy in this family.

Peter Sonier, married Perpetue Savoy.

Second Generation.

Joseph Sonier.
Francois Sonier, contracted leprosy by carrying Ursule Landry's coffin.
John B. Sonier, married a Robicheau, who has had leprosy 40 years; now in lazaretto.
Arthur Sonier, died of leprosy; married a Brideau, who was washerwoman in lazaretto, and escaped.
Ursule Sonier (Mrs. Holmes)—child died of leprosy.
Ide Sonier, first wife of Frank Robicheau, who had 3 wives, died of leprosy; he himself escaped.
Mario Sonier, married Fournier.
Isabel Sonier, married Comeau.

Alexis Sonier, married Charlotte Comeau, who died of leprosy.

Charles Sonier.
Dominick Sonier.
Frank Sonier.
Olivier Sonier.

None of this family, but some of their children, died of leprosy.

A number of Soniers still live in Westmoreland, none of whom ever had leprosy.

THE BRIDEAU FAMILY.

Leon Bricdeau, married a Comeau,	} None of this family died of leprosy.
Louison Bricdeau	{ Marie Bricdeau, married J. B. Arsenau. None of the children, but some of the grandchildren, died of leprosy. Frank Bricdeau, married McLoughlin } Children died Louis " " " " " " " " " " " " " " } of leprosy. Prosper " " " " Robicheau of Pokemouche. Children died of leprosy. Fidele Bricdeau, married Brean. Fidele died of leprosy. Genevieve Bricdeau, married a Vineau. No leprosy. Lawrence " " " Robicheau. No leprosy. Charles " " " Savoy. Children died of leprosy. Matilde Bricdeau, married Ferguson. One child died of leprosy. John B. Bricdeau, married Savoy. Died of leprosy.
Louis Bricdeau.	}

Three brothers, Bricdeaus, came from Paspebiac, in the Province of Quebec about 1790-95.

THE ROBICHEAU FAMILY.

First Generation.

John Robicheau, an early settler.

{ Esther Robicheau,
Fairie " son died of leprosy.
Rachel " died of leprosy; the 6th victim.
John " "
Frederick " "
Joseph " "
Frank " died of leprosy.
May " "

Second Generation.

{ J. E. Robicheau, leprosy.
Mary " married a Savoy.
Margaret " "
Charlotte " "
Daniel " married a Savoy.
Delahid " "
Lazille " "
Batomi " "
Julio " married a Thibadoan.

Frank Robicheau, who had three wives—Ido Sonier, Monica Russel, and Domitia Brideau—all of whom had leprosy, while he escaped the disease.

Margaret Robicheau, leprosy.

{ John " "
Charlotte " "
Louis " "
Olivier " "
Delahid " "
Israel " "

Jos. Robicheau.

Frank Robicheau died of leprosy.

THE COMEAU FAMILY.

About 1790,
Charles Comeau came to Tracadie.
Married Margaret Roy of Bathurst.

{ Charles Comeau, leprosy.
Dominick " "
Joseph " "
Thomas " leprosy.
Alexander " leprosy.
Benoni " leprosy.
Margaret " "
Mary " "
Charlotte " "

None of this family had leprosy.

{ Abraham, These remained in the parish. Children of at least three had leprosy.
Registe, "
Remy, "
Cyprian, "
David, { Married and removed away.
Vivien, { No children had leprosy.
Veronique, { Both married and left the country. None of the children had leprosy.
Tranquille, }

Joseph Comeau, married Thibadeau.	{	Lawrence Comeau, leprosy.
		John B. " "
		Mary " "
		Genevieve " "
		Mary " "
		Vivien " "
		Budger " "
Antoine Comeau, married a Thibadeau.	{	Romain Comeau, leprosy.
		Olivier " "
		Boswell " leprosy.
		Dorothy " "
		Madeline " "
		May " "
		Mary " "
		Genevieve " married
		Mrs. Chas. Losier.
		Mrs. John Losier.
Elvina Comeau, married a Thibeau. Afterwards married An. Sonier.	{	Mary Comeau.
		Alexe
		Eugene
		Margaret
Charlotte Comeau married Goutreau.	{	John B. Goutreau, leprosy.
		Fabian " "
		Clement " "
		Margaret " "
		Mary " "
		Julian " leprosy.
		Veronique " "

A number of Comeaus have been constantly in hospital, descendants of the families.

Charles, Joseph, Antoine, Elvina and Charlotte Comeau were brothers and sisters, who came to Tracadie in early life and married into the neighboring families. Leprosy did not previously exist in the Comeau family, nor in any with whom they became connected, until it broke out with great virulence in the generation given.

It will be noticed that the disease did not exist in the first generation of the Sonier family. This is accounted for by the fact that they were a much older family than the others, and had either died or reached old age before the outbreak of leprosy in the parish. It might be stated here, however, that old age is no absolute barrier to the spread of the disease, as one undoubted case was admitted into the hospital at the age of eighty.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Professor of Gynecology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

The Treatment of Uterine Myoma.—Since my last report a good deal has been written on this subject. The resources of operative gynecology for the treatment of these tumours have been greatly amplified in recent years. Schröder, Martin and Gusserow in Germany, Spencer Wells, Thornton and Lawson Tait in England; and Gaillard Thomas in America, have done the most to bring the surgical treatment of fibroids to its present position. Happily for the sufferers it is only numerically a small proportion of these growths that requires surgical treatment.

Dr. R. Lomer, assistant at the Berlin University Women's Clinic, writes an able paper on the Enucleation of Myoma (*Zeitschr. f. Geb. und Gyn.*, Bd. ix., Hft. 2, Sept. 1883).

He begins by a statement which may be taken as the *raison d'être* of his paper. "Since the recent developments of laparotomy in the treatment of myoma the question of enucleation by the vagina occupies a new position." He refers principally to the recently published results of myotomy by his master, Schröder. These results render it necessary to compare the relative advantages of the two operations and to define the limits of applicability of each. In his opinion, in view of the great mortality after the removal through the vagina of intra-uterine fibroids in cases of undilated rigid cervix; cases in which preliminary dilatation so dangerous is absolutely necessary; the operation of removal through the vagina should be restricted to cases:

1st. Of myoma of the cervix and os uteri, and

2nd. Of submucous and intra-parietal myoma which have dilated the cervix and thereby rendered themselves accessible through the vagina.

The author believes further that for all other cases laparotomy must be performed, and the tumour either amputated or enucle-

ated through the abdominal wall. He emphasizes the great importance in all enucleations through the vagina of the subsequent treatment which is to be the same as for septicæmia in the puerperal woman. The value of continuous irrigation of the uterine cavity now so much employed in Germany in such cases is insisted on, and instances cited from the records of the Berlin Woman's Hospital in which it had a marked antipyretic effect. In two cases in which during the past summer I removed sessile submucous fibroids by the vagina, the after treatment consisted in daily irrigation of the uterine cavity and the subsequent introduction of a few grains of iodoform to the uterine cavity by a suitable instrument. Convalescence was not interrupted by a single bad symptom. In this paper Lomer also discusses those formidable cases of labor complicated with myoma of the cervix, cases in which the tumour lying in the pelvis prevents the delivery of the child. In some such, as in cases described by Playfair, Löhlein and others the tumour can be pushed up at the time of labor. During the past summer, in consultation with Dr. D. C. MacCallum of this city, I saw a case in which this was effected without great difficulty, and the living child delivered by version and forceps to the after-coming head. But in many of these cases this is not possible. In these the author advises incision of the capsule and enucleation in preference to the Cæsarean section so often advocated. In support of this practice he adduces several cases recorded in medical literature and a recent one now published for the first time. This case occurred to Prof. Schröder.

At the recent meeting of the British Medical Association this subject was one of those under discussion. Papers were read by Mr. J. Knowsley Thornton, of London, "On the Operative Treatment of Uterine Fibro-myomata"; on "Myomotomy" by Prof. Carl Schröder, of Berlin; "On the differential Diagnosis of the various Forms of Fibroid Tumours of the Uterus," by Dr. Alfred Meadows, London; and "A case of Hysterectomy for Uterine Fibro-myomata," by Dr. Walter, Manchester.

Mr. Thornton gives the result of his experience in the surgical

treatment of these growths. When subperitoneal and pedunculated, and if they give rise to symptoms he removes them, securing the pedicle by silk ligature. He has operated in cases in which the size—the unsightly swelling of the patient was the only consideration rendering it advisable. In the case of sessile subperitoneal tumours he has operated three times with one death. The cut surfaces were dealt with by ligatures and sutures. He has removed five uterine fibrocysts. All recovered. One was treated by Wells ovariotomy clamp, two by enucleation and ligature, one by cautery and ligatures, and one by simple transfixion and ligature.

For intra-mural tumours, by far the most serious and dangerous of the class he has done partial hysterectomy three times. All the patients died. He thinks that when possible the extra-peritoneal method of dealing with the cut surface is much the safer. He has performed complete supravaginal hysterectomy twelve times, on each occasion removing both ovaries. In these also when possible the pedicle was treated externally; unfortunately, as Mr. Thornton believes, it cannot always be thus treated, but must sometimes be disposed of in the abdominal cavity. Seven of the twelve recovered.

The submucous variety, if single, he treats by rapid dilatation of the cervix with Hegar's wooden dilators and immediate enucleation. Before operating he thoroughly cleanses the vagina and if possible the uterine cavity by antiseptic irrigation before commencing dilatation. After the removal of the growth he sponges out the uterine cavity and wound with tincture of iodine. If necessary to arrest hemorrhage he then uses perchloride of iron. Since adopting this rapid method he has not had the slightest anxiety after enucleation. If these latter tumours are multiple as often happens, and in the great majority of intra-mural growths, he advises the removal of the uterine appendages, an operation for which he believes there is a brilliant future. This latter operation he has done fifteen times without a death. He advocates its performance before the tumour grows large, as then the prospects are by no means so good. His experience is opposed to Lawson Tait's idea that the Fallopian tubes

influence menstruation. He believes, however, that to obtain good results not only must the ovaries and tubes be thoroughly removed, but they must be removed in such a way as that the blood supply of the uterus is very materially influenced by their removal. "In other words the ligatures which transfix the broad ligaments must be so applied as not only to enable us to cut the ovaries and tubes away safely, but at the same time to cut off from the tumour the very important blood supply which it obtains from the enlarged ovarian, tubal, and other vessels."

Prof. Schröder said, "The prognosis of the removal of large solid tumours of the uterus by laparotomy depends altogether upon the development of the technical methods of operating. The important points that are requisite are: 1. A method of operating without great loss of blood; 2. A method of forming a good pedicle, safe against hemorrhage." He then stated that he believed he had found such reliable and not too difficult methods as to make it possible to operate on even the most difficult cases. His method in removing subserous myomata with narrow pedicles in no wise differs from that of other operators. In sessile subserous and interstitial tumours he is generally able to extirpate the growth without the uterus or its appendages. A thin solid India-rubber ligature is placed temporarily round the body of the uterus. The tumour is then removed by V-shaped incisions, or its capsule is incised and it is shelled out. Different layers of stitches are now used; those of the first layer unite the deeper parts of the wound. These are followed by a row of others which conceal the first and so three, four or more rows are applied, the last row of sutures uniting the peritoneal surfaces and alone showing whence the tumour came. In fibroids which develop deep along the sides of the uterus, and push up the Fallopian tube and ovary it may not be possible to spare the organs. But even in such cases he spares the uterus and its appendages as much as possible. In case there is no pedicle around which to place the rubber band, he forms one in the following manner: he severs the appendages by first double-ligaturing the broad ligament with its spermatic vessels, and dividing between these ligatures. The process is

repeated with the round ligament. After this it is easy to separate the tumour from its attachments to some extent, without much hemorrhage. The rubber ligature is now applied tightly around its base. The tumour is then cut off. The stump must be caught by a vulsellum as soon as it is partly divided, otherwise the rubber ligature will be apt to slip off. The opened cavity of the uterus, or cervical canal, is now cauterized with a 10 per cent. solution of carbolic acid to destroy infectious germs that may be present. The stump or wound is treated as in the previous instance by successive rows of silk sutures, the last row uniting the peritoneum only. Prof. Schroeder believes that it will thus be possible to remove by enucleation and with the India-rubber ligature any fibroid, if there be an urgent indication justifying the operation. He has operated on 66 patients and lost 20 (30 per cent.); of the last 40 cases, however, only 9 (22.5 per cent.) have died; and he ascribes these improved results to having operated by his method above described (India-rubber ligature, method of suturing, and enucleation.)

Sir Spencer Wells agreed generally with Mr. Thornton's opinions as to the limitation of operations on uterine fibromyomata. As regards Schröder's methods, he thought that the large drainage tubes might lead to sepsis, and that accumulations of fluids might take place between the rows of sutures.

Dr. Wallace, of Liverpool, urged a greater attention to other than operative treatment. It certainly sometimes caused involution of the tumour. He believed that hemorrhage could nearly always be controlled, he had never seen a patient die of hemorrhage from fibro-myoma.

Dr. More Madden, Dublin, deprecated the excessive, (as he believed,) tendency to operate. From his experience he believed hemorrhage could be arrested, and the patient kept alive for many years.

Dr. Graily Hewitt, London, had seen many cases in which the tumours had disappeared under treatment. He thought enough attention had not been paid to this. (*Brit. Med. Jour.*)

The American Gynecological Society met this year in Phila-

delphia under the presidency of the veteran and venerable ovariologist Gilman Kimball, of Lowell. Several important subjects were under discussion. The limits of this report do not permit of more than an abstract of the most important.

Dr. R. S. Sutton, of Pittsburgh, read a paper on *Cleanliness after Surgical Operations*. He gave results of observations he had made while on a recent visit to some of the great clinics of Europe. He directed attention to the fact that a great change had taken place in surgical methods, and that this is especially evident in the great attention to cleanliness during surgical operations and in the treatment of wounds. The object of Lister's treatment is to keep out germs of organisms found in putrid discharges, and to maintain cleanliness. The result is that surgery is more successful than ever before, and yet the most active opponents of Lister are those who adopt his principles of treatment, omitting the spray or using some substitute for carbolic acid. Strict attention to cleanliness in all the details of the operation and keeping the wounds aseptic are the great principles of Mr. Lister's treatment. Keith is such an expert in cleanliness that he can dispense with carbolic acid. Tait uses the greatest care in securing cleanliness of everybody and everything connected with his operations, so that he can dispense with carbolic acid. These two operators use no disinfectant or germicide yet their results are better than those of any other living operators. German surgery used to be considered extremely dirty, now, a visit to the operating rooms of Esmarch, Volkmann, Schröder, Nussbaum, Koeberle and others, will show the most minute attention to cleanliness, although various minor modifications of the Lister treatment have been made.

Dr. Emmet said he had already expressed the opinion that too often a woman's death-warrant is carried under the fingernail of the surgeon. Since he had been abroad he had trusted to soap and water in preference to other antiseptics. An operator might keep himself clean, but it is very difficult to control his assistants.

Dr. Lusk uses the spray and believes that the dangers from carbolic acid have been exaggerated.

Hot Water in Secondary Hemorrhage after Pelvic Operations.—This was the title of a paper by Dr. Albert Smith, of Philadelphia. He advocated strongly the hemostatic properties of a stream of hot water in the cases mentioned, and to prevent post-partum hemorrhage by using it immediately after the expulsion of the placenta. He had found that hot water would check hemorrhage even in the hemorrhagic diathesis. He made the following points: (1) The great superiority of the hot water douche over all other means of arresting hemorrhage; (2) its efficiency when carried directly to the bleeding surface; and (3) its simplicity. Drs. Reamy, H. P. C. Wilson, Campbell, Mann, Goodell, Barker, and Byford took part in the discussion and in the main agreed with the reader of the paper. Dr. Goodell thought the action of the hot water was remote as well as local, as witness its effects in checking menorrhagia when injected within the vagina. He thought hot water especially useful to check oozing in ovariectomy. For open wounds he preferred vinegar; for post-partum hemorrhage he preferred hot vinegar.

Dr. C. O. Palmer, of Cincinnati, selected: "Some Points connected with Dysmenorrhœa," as the subject of his paper. He remarked upon the frequency of the affection and its troublesome nature to treat. After reviewing briefly the mechanical theories of Macintosh, Simpson and Sims he stated that undoubtedly obstructions do exist and give rise to painful menstruation, but he believed this to be comparatively rare. There are three principal objections to the mechanical theory:

(1). A want of uniformity between the cause and effect, the same amount of obstruction giving rise to different symptoms in different cases. There may be the most severe symptoms attendant on the condition of a cervical canal which at the moment of pain admits the passage of an ordinary sound.

(2). Constitutional treatment is more effective than local measures, iron-tonics and agents that increase the flow of blood relieve the pain.

(3). The course of the menstrual blood may be as uninterrupted in a curved uterine canal as a straight one.

Congenital flexions are generally attended by dysmenorrhœa, but similar conditions acquired in adult life are rare.

The last two points express conclusions recently published by Dr. John Williams and Dr. Ernest Herman, of London, independently of each other.

Reference was made to the extreme sensitiveness of the uterus, at or above the os interum, when the sound is passed, in this disease. The sensory nerves of the uterus are in a state of hyperæsthesia or neuralgia. Sometimes clots may thus act as irritants to the lining membrane, but it is quite clear that they do not always do so. Dysmenorrhœa he thus believed to be in the great majority of cases a functional disorder of the uterus. It is essentially and in its underlying nature a neurosis. It has many features in common with other visceral neuralgiæ. Such persons are usually emotional, sensitive, and impressionable. The local neurosis is an expression of an impaired, disordered, or highly developed nervous system. Imperfect general development predisposes to this neurotic habit, and so do imperfect sexual developments. True obstructive dysmenorrhœa, while it exists, is certainly very rare.

Treatment ought at first to be general in all young unmarried women. He thought local examination and treatment to be very reprehensible in all such cases until constitutional treatment had had a fair trial. In the intervals attention should be given to all means that improve general health. Iron and arsenic—galvanism to the hypogastric plexus and spinal centre sometimes does much good. He had seen decided benefit from prolonged administration of potassic iodide and mercuric bichloride in small doses. It was not in syphilis or in peri-uterine inflammation, but the only lesion was a chronic endometritis and the pain was spasmodic. He had confidence in *cimicifuga* and *pulsatilla* given during the attack. He condemned morphia, which never cures but does great harm to the nervous system. Dilatation by sounds and bougies often relieves stubborn cases, not as a rule by securing a larger canal, but by blunting the sensibility of the uterus, and stretching the irritable fibres of the internal sphincter. Stenosis is more frequent at the os tinæ than else-

where and this explains the greater frequency of sterility than dysmenorrhœa. Stenosis, if not a potent factor in causing sterility, is a most important cause of chronic disease of the uterus—dilatation of the cavity, thickening, softening and granular degeneration of the endometrium—consequently stubborn catarrh. In such cases he thought it better to incise than dilate.

Dr. Chadwick, of Boston, agreed with most of the author's statements. He had given up the theory of obstruction, and never incised except at the external os. Before the period for a week he uses bromides in 10 to 20-grain doses, so as to blunt to some extent the sensibilities. During the period he uses coca and carbonate of ammonia, never morphia.

Dr. Barker, of New York, shared the opinion of the author as to the rarity of obstruction as a cause of dysmenorrhœa. He believed in two sorts of pain; uterine and ovarian. As a tonic he preferred lactate of iron which he combined with chlorate of potash. Apiol had yielded him very good results. His method of administration is to begin two days before the menstrual period by giving it in capsule after meal and continuing it during the period. In cases of ovarian excitement without discharge he gives bromide of sodium in 10 to 15-grain doses. He believes it is less apt to cause the skin-eruption than the potassium bromide.

Dr. T. A. Emmet, of New York, read a paper on "A Study of the Etiology of Perineal Laceration, with a new Method for its Proper Repair." The author affirmed that he had for years paid considerable attention to the subject of perineal lacerations. The suffering ascribed to laceration of the perineum is not proportionate to the extent of the lesion, and as everybody knows some of the severest cases are unaccompanied by symptoms. He directed attention to the anatomy of the pelvic fascia showing its attachment to the pelvic organs, and to the inlet of the pelvis, and declared that these organs are held in place by this fascia, which is continued downwards as a sheath for the vagina. During labour this fascia may be injured or lacerated: when this condition occurs, perineal laceration often follows during the descent of the head and shoulders of a child. Even in

cases without external laceration, relaxation of the vagina occurs and the posterior wall falls away from the anterior one. This rolling out of the mouth of the vagina, as if the drawing string had been broken, exaggerates the appearance of laceration of the perineum, making it seem more extensive and important than it really is. - The operation which he proposed had for its object the shortening of the posterior wall of the vagina, so as to restore to it its relation to the anterior wall. This object is attained by making two crescentic lines of denudation transversely across the vagina, and uniting them by a line of sutures which after the operation are hidden entirely within the vagina. The result is that the perineum is drawn upward towards the pubes, and any laceration existing in it may be disregarded, or it may be united by an interrupted suture. He maintained that we might leave out of consideration, in performing the operation, everything in regard to the external organs outside the line of the hymen. His object was to call special attention to the rôle which the fascia plays in supporting the pelvic organs, and to the fact that the lacerated perineum has little or nothing to do with the symptoms complained of. The discussion shewed that either Dr. Emmet had not made himself perfectly understood or had not convinced the Fellows of the truth of the new doctrine he was endeavouring to promulgate.

Dr. Frank P. Foster, however, agreed with Dr. Emmet when he said that the perineum does not support the uterus, when the parts are normal. The perineum, however, has a function, it serves as a *point d'appui* for a number of muscles.

Dr. R. S. Sutton disagreed with Dr. Emmet. He believed in the perineal body which could be demonstrated in frozen sections. Dr. T. G. Thomas had said that it is better for a woman to break her leg than rupture her perineum, and he (Dr. S.) agreed with him. He, however, admitted that there are many cases that do not require surgical aid. For superficial lacerations he believed that the operation proposed will restore the parts, but when the laceration has extended through the perineal centre he cannot believe it.

Dr. A. Reeves Jackson read a paper entitled, "Is Extirpa-

tion of the Cancerous Uterus a Justifiable Operation?" He said, "In medical and surgical practice the results obtained from any means or method of treatment are proper tests by which their value may be judged." Tried by such tests, he believed this operation to be found wanting. Whenever a therapeutic agent has been found after adequate trial to generally fail in effecting the purpose of its use or to be habitually dangerous to life, candid and honest men have ceased to employ it." He deprecated the rapidly growing tendency to a bold, fearless, even reckless progressiveness in surgery. He said it is notorious that in almost all instances in which surgical operations have been done for the removal of cancers, they have only been of temporary benefit—if beneficial at all. However, when these were free from danger to life, so long as they did no actual harm, they were doubtless proper in many instances, because they added for a time to the patients' comfort. They rarely did more than this. But when the operations themselves become so dangerous as to destroy 70 per cent. of lives within a few hours, or a few days; and when, of the few who escape the operation, 50 to 75 per cent. die from recurrence of the disease within a few months; and when, further, of those who yet remain, all, or nearly all die, as soon as though no operation had been performed, we should halt to consider whether our calling thus exercised is beneficial or injurious.

By Freund's abdominal method the mortality is frightful. By the latest table of 91 cases—66 died; 25 recovered. Czerny, Schroeder, Martin and others have operated extensively by the vagina with much better results. Sanger's table of 143 cases, published in the *Archiv. f. Gyn.*, 1883, shows recoveries, 72 per cent.; deaths, 28 per cent.

Dr. Jackson then stated that in his opinion extirpation of the uterus does not save, but destroys life. "In order to show how much life has been sacrificed by it, I accept all the known fatal operations as the full number, although it is certain that there are many more. They amount to 159 cases—97 abdominal and 60 vaginal. If we grant that in all these cases the disease affected the cervix, and that the average length of life is

seventeen months, the calculation would show more than 222 years of life—over two centuries—sacrificed by the operation. If we consider that in many of the cases the disease affected the corpus uteri, as it surely did, in which the average duration of life is $2\frac{1}{2}$ years, the aggregate amount of life destroyed would be even greater.

He summarized as follows :

1. Diagnosis of uterine cancer cannot be made sufficiently early to ensure its complete removal by extirpation of the uterus.

2. When the diagnosis can be established, there is no reasonable hope for its radical cure ; and other methods of treatment, far less dangerous than excision of the entire organ are equally effectual in ameliorating suffering, retarding the progress of the disease, and prolonging life.

3. Extirpation of the cancerous uterus is a highly dangerous operation, and neither lessens suffering—except in those whom it kills—nor gives reasonable promise of permanent cure in those who recover. Hence, it fails in all the essentials of a beneficial operative procedure, and should not be adopted in modern surgery.

Dr. Van de Warker said he took substantially the same ground as that held by Dr. Jackson. He operated by removing all the diseased tissue by scraping out. He then used Monsell's solution of subsulphate of iron to check bleeding. Subsequently the hollowed out cervix is packed with cotton soaked in a saturated solution of chloride of zinc ; the result is an enormous slough of the cavity of the uterus. He exhibited a number of sloughs that were removed in this way. One of the specimens had been removed 18 months ago, and the woman was still well.

Dr. Emmet, of New York, was much pleased with the paper because it expressed his own views with reference to the operation. His experience is confined to one case and that was unsuccessful. It was done through the abdominal incision. If the operation is ever to be done, it should be done by the vagina, and should be confined to removing the uterus for sarcoma.

Dr. Baker, of Boston, described his operation for removing the entire supra- and infra-vaginal portions of the cervix as well

as from one-third to one-half of the body of the uterus. He has operated at least 30 times without a single death, and he can recall six cases, of at least 9 years standing, which have absolutely recovered. The cases in which total extirpation of the uterus is advisable are extremely rare, and comprise those in which the disease begins in the cavity of the uterus.

Dr. C. D. Palmer, of Cincinnati, said that so far as total extirpation of the uterus for cancer is concerned, the cases belong to one or other of two classes: 1. Those in which it is clearly unjustifiable. 2. Those in which it may be justifiable. The first would include almost every case of cancerous disease beginning in the cervix. The second would include those cases of sarcoma starting in the uterine body, which are very rare. It is usually impossible to determine whether the disease has extended beyond the uterus itself.

Dr. Sutton, in speaking of the removal of the uterus per vaginam, said it is not so fatal as ordinary ovariectomy. Schröder lost only one out of thirteen from the operation, and Martin had told him that his longest case lived twenty-two months after the operation.

Dr. Sutton then described the operation as performed in Europe. The patient is placed in the lithotomy position, and Simon's speculum is used to elevate the anterior vaginal wall and depress the posterior. Lateral retractors are also used. In order to prevent the constant presence of blood in the vagina, a stream of carbolized water is thrown in. An incision is made across the cervix, just below the vaginal attachment. A curved needle is then passed through the upper lip of the incision and the ends drawn out together and turned over the pubes. With the thumb nail everything above the cellular tissue is skinned back until the perineum between the bladder and the uterus is reached. The incision is then carried across the neck. The posterior lip is next treated in the same way. The peritoneum is then opened and the opening dilated with the finger. A volsellum forceps is next passed through the opening grasping the fundus and drawing it into the vagina. With a curved needle a double ligature is passed through the broad ligament and firmly tied.

A clamp forceps is applied to the ligament, and it is then cut. The uterus is then drawn down and the ligament on the opposite side treated in the same way. The opening in the vault of the vagina is not sewed up. Schröder puts a large drainage-tube into the pelvic cavity, one end of the tube being outside of the vulva:

The vagina is then packed with cotton saturated with iodoform. Martin sometimes simply stuffs the vagina with antiseptic material, and the patients recover. So far as the advisability of the operation is concerned, he had not made up his mind.—(*Medical News*, Philadelphia; *Philadelphia Medical Times*, September, 1883).

Reviews and Notices of Books.

A Treatise on the Diseases of the Eye.—By J. SOELBERG WELLS, F.R.C.S. Fourth American from the third English edition, with copious additions by CHAS. STEDMAN BULL, A.M., M.D., Lecturer on Ophthalmology in Bellevue Hospital Medical College, Surgeon to the New York Eye Infirmary, &c. Illustrated with 257 engravings on wood and six colored plates; 816 pages. Philadelphia: Henry C. Lea's Son & Co.; Montreal: Dawson Bros.

Anyone desirous of obtaining the most complete work on diseases of the eye in the English language will find in this treatise the fulfilment of that desire. The original work, by the late lamented J. Soelberg Wells, has for so many years held the front rank as a standard authority on ophthalmology that nothing more requires to be said in its favor except that the book is to the present generation what that of Mackenzie was to the past. Mr. Wells still lives in the memories of those who had the privilege of knowing him personally as a genial and kind-hearted man, a courteous and polished gentleman, a skillful practitioner of his art, and an accomplished scholar, and it is a pleasing circumstance that the perpetuation of his great work has fallen to the lot of one so well qualified for the task as the present editor, Dr. Chas. S. Bull, who, in addition to being already well known for his original work, scientific and clinical, has a thorough knowledge of ophthalmic literature, such as can only be attained by

those who are familiar with the most important modern languages. The book, as edited by Dr. Bull, although containing only a few pages more than the third English edition, is more closely printed, and in reality one-fifth longer as to reading matter. This addition to the size of the volume is caused by the numerous paragraphs inserted by the editor in order to bring the work up to date, and may be taken as a brief, but very excellent, *resumé* of the progress made in ophthalmology during the past ten years. The editor has been singularly happy in following the style of his author, and the whole is so harmoniously combined as to read like the writing of one man. It is no exaggeration to say that there are few more readable books in medicine than this; certainly no medical library can be considered complete without it.

Excision of the Knee-Joint, with report of 28 cases.

Illustrated by 13 photo-lithographs and wood engravings.

By GEO. EDGEWORTH FENWICK, M.D., C.M., Professor of Surgery, McGill University; Surgeon to the Montreal General Hospital. Montreal: Dawson Bros.

The subject of excision of the knee for disease and other conditions affecting the usefulness of the limb is one to which Dr. Fenwick has devoted a great deal of attention. His results have been eminently satisfactory and encouraging, so much so that he is anxious to assist in dispelling any doubts that may have arisen as to the value of the operation. This monograph consists of two parts. The first gives an account of the operation as first devised and practiced, and its standing and procedure at the present day as judged by the most recent writings of eminent surgeons. This section also includes the author's remarks upon the character of the cases which he considers suitable for excision, the various modes of after-dressing, and the appliances therefor, with illustrations of those which he has found to answer best. Some modifications in the operation—notably the rounded section of the bones—are peculiar to Dr. Fenwick himself, and the latter, in his opinion, has proved a decided improvement. The second section gives detailed reports, with a table, of his series of cases. Some of these have already been published, but are now re-introduced with later cases in order to complete

the entire number. We take much pleasure in introducing this book to our readers, many of whom are counted amongst the author's numerous friends and former pupils. It is an excellent and practical contribution upon an important subject, based upon the personal experience and careful observations of one who has long deservedly held a prominent place amongst Canadian surgeons. It is nicely printed, and the lithographs are excellent.

Gout in its Protean Aspects.—By J. MILNER FOTHERGILL, M.D., M.R.C.P., Lond., Physician to the City of London Hospital for Diseases of the Chest; Hon. M.D., Rush College, Chicago, &c. Detroit, Mich.: George S. Davis. 8vo.; pp. 300.

Dr. Fothergill is well known as one of the prolific writers of the present day, and his physiological attainments and therapeutical researches render him peculiarly well fitted for the production of such a treatise as the present. The disease, gout, to which the greater part of it is devoted, is, fortunately (for the public), a very rare affection in this country. Its study, therefore, does not command the same attention from the practitioner here as elsewhere. Still, it is one of the constitutional disorders which, from its interesting pathology, far-reaching complications and often obscure symptoms, will always be studied with renewed zest by the scientific physician. Special consideration is given by the writer to the subject of the nervous manifestations of gout, as these special disorders are said to have been becoming of late years more common than the more pronounced and acute inflammatory attacks. The recent views on the pathology are all worked out, and chapters are given on the diagnosis, etiology, prognosis and treatment. The pleasant mode of writing of this author renders the book uncommonly readable, whilst the whole shows considerable originality and careful observation. Dr. Fothergill is the arch-enemy of the nihilists in therapeutics who so predominate at the present day, and on this account alone his book is worth reading and having students read. Even in connection with so-called rheumatic gout (*arthritis deformans*), that hopeless-looking complaint, Dr. F. would by no means admit the pessimist view so commonly taken by writers. He would,

on the contrary, insist upon patient examination of an early case, with the object of determining, if possible, the general systemic fault which is likely to be present, and upon persevering efforts to remove this by climate, natural waters, internal medication, local means, &c., and declares that, even in unpromising cases, our efforts will not unfrequently be rewarded by a fair share of success. He concludes by a short chapter on Chronic Rheumatism, and one on "Some general considerations on Indigestion, Biliousness, Diabetes and Gout."

The Untoward Effects of Drugs: A Pharmacological and Clinical Manual.—By Dr. L. LEWIN, Docent of Materia Medica, Hygiene and Public Health in the University of Berlin. Second edition, revised and enlarged. Translated by J. J. MULHERON, M.D., Professor of Principles of Medicine, Materia Medica and Therapeutics in the Michigan College of Medicine, Detroit, Michigan. George S. Davis, Detroit Mich.

In teaching or learning the symptomatology of disease, it is necessary to teach or learn from cases taken as types of each separate group of diseases: but the student soon finds that, in the great majority of cases, the type has to be sought for amongst many casual conditions which may at first sight appear not to belong to it at all. These are to be obtained chiefly by experience. So with a knowledge of drugs. The teacher describes, and the student comes to know, the recognized actions to be expected from the exhibition of a certain drug. When, however, that drug is given, certain other results may be observed which are unexpected, or unusual, and may, perhaps, be attributed to some other cause, when, in reality, they were effects proper of the drug in question. Again, there are many drugs whose special action in disease it may often be extremely desirable to procure, and yet they possess as well the property of affecting, in some unwished-for manner, certain other functions or organs. For many reasons, therefore, it is important for the advanced student in therapeutics and for the practical physician to have some sort of reference to which he may go for the explanation of these points. Many of the facts to be found in this book are already fully recognized in the text-books of Materia Medica,

but a multitude of details and valuable information in connection with these points only exists scattered through the periodical literature of many years past. This book collects all these in a systematic form, and presents them in such a way that anything sought for can be found under its appropriate heading. Numerous references also are given, when important drugs are discussed, so that one interested in the matter can refer to the original articles. Thus, any one observing what is apparently an effect of a drug of an unusual character can at once here ascertain what the most recent authorities have to say on that particular subject. The scope of the work, it will thus be seen, is somewhat original, and the object of the author has been thoroughly worked out. We have no doubt that this book will be largely availed of throughout the profession and by many of our senior students.

A Pocket-Book of Physical Diagnosis of the Diseases of the Heart and Lungs, for the Student and Physician.—By DR. EDWARD T. BRUEN, Demonstrator of Clinical Medicine in the University of Pennsylvania, and Assistant Physician to University Hospital, &c. Second edition; revised, with additional illustrations. Philadelphia: P. Blakiston, Son & Co.; Montreal, Dawson Bros.

A concise and practical exposition of the physical signs of the organs of the thorax, normal and diseased. The descriptions are made very intelligible, and a feature of the little book consists in the introduction of a number of original drawings from actual cases, which serve to impress the reader more particularly with the points under consideration. We can recommend it specially to advanced students, to assist in their studies and for reference at the bedside.

The Practitioner's Ready Reference-Book: A handy Guide in Office and Bedside Practice.—By RICHARD J. DUNGLISON, A.M., M.D., author of "A New School Physiology," "Medical Dictionary," &c. Third edition, thoroughly revised and enlarged. Philadelphia: P. Blakiston, Son & Co.

We have already had occasion to notice most favorably the

earlier editions of this useful book. This, now the third, comes to us very considerably enlarged, and containing a good deal of new matter, all of which is quite appropriate, and certainly adds to its value. From a long list of the specialties, to which we are now introduced for the first time, we make the following selection, which will serve to show the wide range of subjects covered, viz., Nutritive Enemata (new formulæ); How to apply Bandages; Treatment of foreign bodies in the Eye and Ear; Treatment of Frost-bite, Sprains, Spitting of Blood, Insensibility, Suffocation, and Sunstroke; How to make Poultices; Vapor Baths; How to lift helpless patients; The collection of dates at, and how to preserve the record of, Autopsies. To every practitioner it will be useful; to every young practitioner it will prove a mine of practical hints to serve him in all emergencies, and to help him in all the minor details of practice to which he is yet a stranger.

Transfusion: Its History, Indications, and Modes of Application.—By CHARLES E. JENNINGS, L.R.C.P., Lond., Fellow of the Obstetrical Society of London, &c. With engravings and a bibliographical index. London: Baillière, Tindall & Cox.

This is a book of small dimensions—in fact, so small that the author begins by making excuses for it. He “feels himself in the position of that Greek nobleman who, having invited a number of distinguished guests to attend the funeral of his infant daughter, apologized for bringing so small a corpse before so august an assembly.” In reality, however, it requires no apology, for it contains much that is valuable and interesting concerning an operation which, though seldom called for, is still sometimes the only means by which life can be saved. The scope of the monograph is clearly enough indicated by its title. Few persons have had much experience in transfusion, and anyone about to operate will do well to study Mr. Jennings’ remarks thereon, as he will find many hints which will serve to obviate practical difficulties standing in the way of its successful accomplishment. The woodcuts illustrate the author’s syphon for intravenous injection and immediate transfusion.

Books and Pamphlets Received.

CRUISE OF THE REVEVUE-STEAMER CORWIN IN ALASKA AND THE N. W. ARCTIC OCEAN IN 1881. Notes and Memoranda: Medical and Anthropological; Botanical; Ornithological. Washington: Government Printing Office.

THE TREATMENT OF WOUNDS: ITS PRINCIPLES AND PRACTICE, GENERAL AND SPECIAL. By Lewis S. Pilcher, A.M., M.D. New York: William Wood & Co.

TYPES OF INSANITY: AN ILLUSTRATED GUIDE IN THE PHYSICAL DIAGNOSIS OF MENTAL DISEASES. By Allan McLane Hamilton, M.D. New York: Wm. Wood & Co.

THE MEDICAL STUDENT'S MANUAL OF CHEMISTRY. By R. A. Witthaus, A.M., M.D. New York: Wm. Wood & Co.

A PRACTICAL TREATISE ON THE MEDICAL AND SURGICAL USES OF ELECTRICITY, including Localized and General Faradization; Localized and Central Galvanization; Franklinization; Electrolysis and Galvano-Cautery. By G. M. Beard, A.M., M.D., and A. D. Rockwell, A.M., M.D. Fourth edition. New York: Wm. Wood & Co.

A MANUAL OF PATHOLOGY. By Joseph Coats, M.D. With 339 illustrations. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

CHEMISTRY: GENERAL, MEDICAL, AND PHARMACEUTICAL; including the Chemistry of the U.S. Pharmacopœia. A Manual of the General Principles of the Science and their applications in Medicine and Pharmacy. By John Attfield, F.R.S. Tenth edition. Specially revised by the author for America. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

THE COLLECTIVE INVESTIGATION OF DIPHTHERIA AS CONDUCTED BY THE THERAPEUTIC GAZETTE, DETROIT, MICH. With Editorial Summary. By J. J. Mulheron, M.D. Detroit, Mich.: George S. Davis.

THE TREATMENT OF WOUNDS AS BASED ON EVOLUTIONARY LAWS. By C. Pitfield Mitchell. New York: J. H. Vail & Co.

THE PATHOLOGY AND TREATMENT OF VENEREAL DISEASES. By Freeman J. Bumstead, M.D., LL.D., and Robert W. Taylor, A.M., M.D. Fifth edition, revised and rewritten, with many additions, by Dr. Taylor. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

CHEMISTRY, INORGANIC AND ORGANIC, WITH EXPERIMENTS. By Charles Loudon Bloxam. From the fifth and revised English edition. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, September 21st, 1883.

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

Dr. Trenholme exhibited the ovaries and tubes which he had removed three weeks ago from a patient, 24 years of age. She had suffered from dysmenorrhœa, with pain continuing after the period, making life miserable. The ovaries were removed by abdominal section under the spray. Both were hypertrophied

and tubes congested, there was also congestion of the uterus. Patient made a perfect recovery.

Dr. Trenholme also shewed an ovarian tumor removed by him thirteen days ago. Patient was 24 years of age. Was sent to him from the country. Had suffered for four years, distress gradually increasing, but tumor had been only recently discovered. Dr. T. found a large tumor to the left of median line, and diagnosed cyst of left ovary. On opening the abdominal cavity and examining, was found to spring from the right ovary, and weighed twelve pounds. Patient did well; highest temperature was on 8th day, 100.2°, from a slight bilious attack. Dr. Young gave the following description :

Right ovary expanded by pressure, yet apparently healthy, as proved by the normal condition of the ova, which are shown as coming to maturity. There are three cysts, the covering of each being continuous with the covering of the ovary; they are all extra-ovarian, *i.e.*, the tissues of the ovary are not involved in their development, but the capsule of the ovary constitutes the covering of the cyst. Each cyst contained serous fluid, and on the wall nearest the ovary a small *sac* containing a grumous yellow mass was found, suggesting the possibility of the retention of the *ova* in the covering of the ovary as giving rise to inflammatory action in the middle cyst. Exactly over this yellow pigmentary deposit was a *warty* fibrous excrescence, which also favors the idea of irritation from non-escaped ova being the cause of the cystic development. The left ovary is much enlarged; covering dense, otherwise healthy.

DR. HENRY HOWARD wanted to know if Dr. Trenholme only performed "Lait's" operation as a *dernier ressort*—that is, after trying other means for relieving the symptoms—as he thought there might be a danger now-a-days of resorting to spaying without a fair trial of less heroic treatment.

DR. FENWICK read a paper on *Ligature of the Axillary Artery in a case of traumatic injury to that vessel after fracture of the surgical neck of the humerus*. The following are the principal points in the case :

Eliza C. B., aged 41, a spare, delicate-looking woman, was admitted into the Montreal General Hospital, on May 30th,

1883. While walking in the street a piece of heavy timber fell from a building; it broke in two, and the upper half struck her on the shoulder, breaking the humerus at its upper third, about two inches below the joint; the upper fragment was drawn forcibly inwards, and lacerated the brachial artery at or about the point of the commencement of that vessel. On examination, the shoulder was greatly swollen, the axillary pit brawny, and filled with what appeared to be blood; there was considerable tumefaction beneath the pectoral muscle, extending as high as the clavicle. The entire upper part of the front of the chest and axilla was tense and mottled; there was absence of pulsation below. On examination with the stethoscope, the pulsation could be traced down to a point about an inch below the fold of the axilla, and at this point there existed a circular abraded surface about the size of a shilling. This was situated over the position of the artery, and below this point all evidence of arterial pulsation ceased. The forearm and hand were greatly congested, the vein distended almost to bursting, the color of the skin was dark and mottled, the limb cold, the temperature being below the normal standard. A consultation of the surgical staff was hastily summoned, and in the meantime the limb was supported on a pillow, and hot flannels applied to restore warmth and favor the circulation. In consultation it was suggested to make an exploratory incision over the course of the vessel, ligate it above and below the point of injury, and turn out as much of the blood-clot as possible to relieve tension and endeavor to save the arm. During the two hours which had elapsed the same state of things existed, if anything in an aggravated form, the superficial stasis and coldness of the limb had extended, and the swelling had increased; the pulse, which at the former visit was moderately full and 80 per minute, had become more rapid and somewhat weaker, and there was perfect absence of sensation as high as the middle of the arm. The patient was placed under ether, the subclavian artery was compressed with the handle of a door-key, where it passes over the first rib. The arm being by the side, an incision three inches in length was carried down directly over the situation of the artery; the centre of the incision being at the point where pulsation had

ceased, as ascertained by the stethoscope. A large blood-clot was removed, and the artery and median nerve hooked upon the finger; the wound in the vessel was quite apparent, and carbolized catgut ligatures were applied above and below the injury. The upper ligature was applied at the point where the vessel passes over the tendons of the teres major and latissimus dorsi muscles, which were quite visible. As much of the blood-clot as possible, without disturbance of the parts, was pressed out. The injury to the bone was a simple transverse fracture; the upper fragment was lying in front, and drawn inwards; the lower fragment was drawn upwards and outwards, and there was shortening of about an inch and a half. Extension of the limb brought the fragments near together, and, by a little manipulation, the broken ends were accurately adjusted. The wound was cleansed with a warm solution of 1 to 40 of carbolic acid, the wound closed with catgut sutures, and dressed with the usual antiseptic dressing; outside of the dressing, two pieces of Gooch's splinting were fitted, and retained in position by a couple of bands of ordinary bandage, and the hand and forearm swathed in a flannel bandage. The operation was performed under the spray, and with full antiseptic precautions. There was one circumstance which was noticeable at the time of the adjustment of the fragments—a large clot was liberated and came away, and the veins, which previously were flaccid and empty, at once became distended, and the stasis in the forearm and hand was relieved. Before applying the flannel bandage the parts had assumed a more natural hue. At night she was very comfortable; there had been considerable draining away of serum tinged with blood; the color of the forearm and hand was natural, and the warmth of the limb appeared to be that of the rest of the body; there was, however, no pulsation to be felt at the wrist.

May 31st.—She had passed a fairly good night, had slept at intervals, and had taken nourishment in small quantity, principally milk. The evening temperature was 101° , and had fallen to 99.2° in the morning. There was no pulsation at the wrist. Very little discharge had escaped since night, except bloody serum, which had apparently dried, so that I did not disturb the limb by changing the dressing.

June 1st, 1 p.m.—I dressed the arm to-day ; the wound was looking well ; discharge trifling, and of the same character. The fullness about the front of the chest beneath the clavicle had greatly lessened. The same dressing was applied. On careful examination, the pulse was distinct at the wrist, though small in volume as compared with the opposite arm. This was forty-five hours since the ligation of the vessel, and about forty-eight since the accident.

From this time forward she progressed slowly, but favorably ; the wound closed, and union between the broken fragments of bone took place, and the patient left the hospital towards the end of July.

DR. FENWICK said :—This was a case of unusual occurrence, and is of interest in illustration of the surgical principle of ligating a vessel at the point of injury. There are other conditions connected with the case which might render this line of practice objectionable, and to which exception might be taken, as the converting a simple into a compound fracture. The case was desperate, and one of two things had to be done : either ligate the vessel, and endeavor to save the arm, or practise amputation at the shoulder joint. The conversion of a simple into a compound fracture, always a serious injury, and to be avoided if possible, is less feared now, with the use of antiseptic means, which, in this instance, were fully carried out. A most interesting circumstance connected with this case was the accuracy with which we were enabled to ascertain the actual point of injury to the vessel by the use of the stethoscope ; the humming of the artery could be distinctly made out to cease at a given point, opposite to which was an abraded portion of skin and exactly at this point the wound in the vessel was found. Another point of interest was the return of the radial pulse forty-five hours after ligation of the vessel.

DR. HINGSTON approved of Dr. F.'s treatment of the case, and thought that no alternative should have presented itself but to cut down to the middle of the surface and ligate the vessel.

DR. SHEPHERD, who assisted Dr. Fenwick, said that why they thought of amputating was because of the condition of the

parts—the tissues were much swollen and dark, the clavicle could not be felt. Amputation has been resorted to in similar cases by London surgeons.

In answer to questions by members, DR. FENWICK, said the vessel was not cut between the ligatures ; collateral circulation was established in a few hours, as shewn by the limb becoming warm and good color. There would have been more danger of secondary hemorrhage if he had tied the subclavian, for the distal end of the artery would be open, and collateral circulation would set up secondary hemorrhage.

DR. HINGSTON exhibited *An Uterus*, removed by him on account of a generally diseased condition and persistent sweating of blood after separating a very firm adhesion between it and a thirty pound ovarian tumor. The other ovary being diseased was also removed. The shock was not great. Operation was performed three days ago. Patient is doing well, temperature and pulse under 100 ; no vomiting. Did not use the spray, but carbolic acid mixed with water on all the instruments and dressings.

DR. SUTHERLAND exhibited two specimens of extensive sarcomatous disease of the ilium.

DR. SMITH reported a case of aphonia from pressure of a thyroid abscess, occurring as a complication in pneumonia. The symptoms disappeared on opening, and giving vent to the pus.

Annual Meeting, October 12, 1883.

The retiring President, Dr. Kennedy, gave the following address :

GENTLEMEN,—Your kindness in electing me to the office of President of this Society at your last annual meeting has, among other things, invested me with the responsibility of presenting an address to-night which, in some measure, is expected to bring before you a review of our work during the year just ended. This Society has now been in active existence for many years, and its history shows that ever since its formation, or should I rather say regeneration (for it may be looked upon as the successor of previously existing societies), it has manifested a vitality which promises to maintain its existence for an indefinite period. The influence of such a society as this must always be beneficial :

bringing into friendly intercourse members of our profession who otherwise might not have the opportunity of becoming properly known to each other, obliterating personal hostilities, and exchanging distrust and prejudice for a respect for the opinions of others and sympathy in the life-work of each individual whose lot is cast among us. There can be no better mode of cultivating a true friendly spirit and generous rivalry, or of inculcating a regard for rules of ethics, for it becomes impossible not to uphold the professional repute of one member when accustomed to meeting him here in friendly discussion. It engenders a feeling of respect for our profession which in its reaction elevates that profession in the minds of the public. This social aspect of our meetings I regard as not the least valuable feature in them. If, however, these meetings had no other end than the pleasure of meeting each other, if it accomplished no other good than affording opportunities for social intercourse and the interchange of personal courtesies, binding together those having identical aims and aspirations in their high calling, good would result. But we assemble for graver purposes in the progress of medical science and art. As in other departments of human activity the range of learning and discovery is ever enlarging its boundaries, and, therefore, we come together each to bring his contribution to the common fund of facts from which the laws of disease and the instruments of its alleviation are to be derived, and by enlightened discussion record our observations which otherwise might be lost or hidden within the chambers of our memories.

The Society has held its meetings only eighteen times during the past year, an unusually small number. This has been due to the difficulty of obtaining papers from our members. This is a difficulty which requires a remedy. Many members attend our meetings regularly, but do not add anything to our work or contribute but little to the discussion which take place. Original papers cannot always be expected, nor is it desirable that we should confine our discussion to extraordinary forms of disease. I think that we are too apt to look for something brilliant in what is brought before us, overlooking that which might be called common but which, if attention was directed to it would excite a strong debate and refresh our ideas in regard to the treatment of such disorders. It would certainly teach us to avoid a mere routine, and, speaking for myself, I am pleased to say that attendance on these meeting has given me many a useful hint and added instruction on many points which otherwise might not have been obtained. I trust that my successor will be able to make a better return at our next annual meeting,

and that our secretary will not find it so difficult to obtain papers in future. Several of the papers have been hurriedly prepared to fill the want, otherwise fewer meetings would have been held. One very valuable one was by Dr. Osler and Mr. Clement on Parasites in the Pork Supply of Montreal. To the meeting at which the paper was presented members of the Board of Health and other interested persons were invited. From a sanitary point of view it was specially valuable, and much credit is due to the gentlemen who had taken so much trouble in bringing it before you. I am afraid, however, that it has had but little influence in producing any result, so far as our sanitary authorities are concerned.

In addition to papers we have had interesting cases in practice related by several of our members which, in some instances, excited considerable discussion. Patients suffering from peculiar forms of disease have been shown by Drs. Hingston, Gurd and Wilkins, and a large number of pathological preparations exhibited, chiefly by Dr. Osler—on whose labors in this line I need not dilate—and also by Drs. Ross, Bell, Shepherd, Wilkins, Alloway, Fenwick, Gardner and Trenholme. These preparations, though gratifying to our visual organs and instructive to our mental faculties, did not always invest our persons with the odor of sanctity. Among matters which may be termed miscellaneous may be mentioned the reporting of the proceedings of the Society by our medical journals, under the supervision of a publishing committee. This arrangement has worked fairly well, and has done much, I think, by giving due publicity to our work, in interesting country practitioners who, from their positions, are unable to become workers in any society; besides it furnishes a record which will be found useful to the future compiler of the medical history of the city. To our Secretaries we are indebted for the able manner in which they have performed their really arduous duties in this respect, and you have acknowledged this service when bidding adieu to the gentleman whom you elected to the office last year. Dr. Henderson proved himself an efficient worker whom we could ill afford to lose, but I am happy to state that in the new sphere of his labors he is meeting with that deserved success to which his merit entitled him. Though some familiar faces are not with us to-day, their work being elsewhere, new members have joined us, and keep up the number of our roll call. Rarely does a twelve months elapse without having the lesson exemplified “that in the midst of life we are in death.” We have been called upon to mourn the loss of two old familiar friends; both ended lives of usefulness and industry at an advanced age. In their loss we

mourn no unfinished career, "cut untimely off,"—I allude to the death of Dr. David and of Dr. Scott. The former, once President, has left us a valuable record of the early history of medicine of this city in his reminiscences, which were read at a meeting of the Society shortly before his death; and to those of us who knew him as an active member of the profession he will be remembered with that kindly respect which an upright and able life-work prompts us to feel. The latter will also long be remembered by those whose privilege it was to listen to his teaching which had extended over so many years.

Passing from these sad memories I recall to your recollection the pleasant meeting which was held during the last Xmas holidays. I was, unfortunately, unable to attend, but, from what I heard of it, the relaxation from graver matters, though it may not have advanced science, tended to promote harmony and goodfellowship and will, I hope, be followed by like meetings at similar seasons in future.

In conclusion, let me thank you for the courteous manner in which you have borne my deficiencies as Chairman. Circumstances over which I had no control prevented me from being present at more than ten meetings, but I have endeavored to fulfil the duties imposed on me, and, as a member, I shall ever take a deep interest in the work of the future.

The following officers were elected: President, Dr. Rodger; 1st Vice-President, Dr. Cameron; 2nd Vice-President, Dr. Osler; Secretary, Dr. Gurd; Treasurer, Dr. Molson; Librarian, Dr. Foley.

Council—Drs. Ross, Campbell and Buller. Publishing Committee—Drs. Ross, Cameron, Osler and Kennedy.

DR. WOOD read a paper on "Treatment of Urethral Stricture."

DR. HINGSTON took exception to Dr. Wood saying his case was cured, and thought he ought to examine him again, for even after years he had known them to relapse, especially when treated by dilating. In dilating we should not stop with No. 12, as 18 was more like the full size of the male urethra. Dr. H. said it was extraordinary how surgeons differed in their treatment of these cases: Otis strongly advocating internal urethrotomy with dilatation, while an eminent surgeon of Boston dilated the urethra so forcibly as to tear the stricture. This surgeon told Dr. H. that it was their practice at his hospital always to so treat stricture, and that the results were most satisfactory. All these methods were good, but the difficulty lay in

finding out which will suit your case best. At a meeting long since, he advocated internal urethrotomy as best for most cases, but now believes that ascertaining the size exactly before and behind the stricture, so as to dilate to the fullest, gives the most satisfaction. The tolerance of the urethra indicates which method to employ. Some being most intolerant, and, after passing of an instrument, are followed by high fever, and even death has resulted from simply using a bougie or catheter. One instance he knew of where the person dropped dead at once. Has noticed that French Canadians are very tolerant. Dilatation with division is the latest treatment, and the one now most used. There is no necessity for dividing if you can get through a No. 6 English. The two kinds of stricture most difficult to treat are the very small and very large. If calibre very much narrowed, he either gets in a piece of whale-bone and passes others by the side of it or else the pathfinder, and over it sends the urethrotome, and cures at once, by dividing. Believes division also best for slight stricture in a large urethra.

DR. WILKINS said, when treating cases in hospital, if found the calibre very much narrowed, he introduced a whale-bone probe, and then Otis' modification of Thompson's divulsor, and dilated to full extent, but often had sharp and troublesome fever follow. Lately has been well satisfied with gradual dilatation by means of Lister's sounds.

DR. SHEPHERD said he believed Dr. Wood's case to have been one of hypochondria, and that the man had inflamed his urethra by treating himself. Dr. Shepherd treats stricture by gradual dilatation, excepting the resilient kinds which must be cut. He never knew a case of real stricture to be permanently cured. Has several times seen urethral fever follow the passage of a bougie. Has a patient now, who has fever follow each passage of bougie, and believes this to be a case for division.

DR. MCCONNELL criticised Dr. Wood's prescription, and said the fact was well established now that Liq. Potassæ and all mydriatics were incompatible.

DR. WOOD replied by saying that, if well diluted, Liq. Potassæ and the mydriatics would retain their virtues for a few days. The Liq. Potassæ in his mixture of hyoscyamus was well diluted,

and only enough at a time was made to last three or four days. Dr. W. was sure his patient had stricture, and that now he was cured.

DR. RODGER said he used gradual dilatation but often saw relapses.

DR. CAMPBELL was astonished at Dr. Shepherd saying he never knew of a permanent cure. Dr. C. knows of many gentlemen in this city whom he had treated twelve or fifteen years ago, and who are now fathers of families, and who have not been troubled with their strictures since.

DR. H. HOWARD suggested that, perhaps, the reason for their not having stricture, after being married might solve the riddle by shewing that the relapses spoken of by the members were nothing more than new attacks.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

This Society commenced its winter meetings on Friday, the 26th October. The President, Dr. Robillard, in the chair.

During routine business, the "card" of an enterprising local practitioner was exhibited, and caused much amusement. The custom of advertising as specialists in the diseases of certain viscera was also discussed and disapproved.

The paper of the evening was presented by Dr. H. P. Wright, upon "*London Hospital Work*," being an outline of his observations during a recent visit to that city. He sketched the methods of work in the various institutions, remarked upon the views held by many of the surgeons in their special lines, and gave the treatment adopted by many of the specialists. A Simpson's Traction Forceps was exhibited, an instrument which he considered very valuable as an aid to the obstetrician. At the conclusion, a lengthy discussion followed, and a hearty vote of thanks accorded for the valuable and interesting paper.

DR. GRANT related a case where a belladonna plaster over the epigastric region had cured a case of severe nausea and vomiting in early pregnancy.

The CHAIRMAN called the attention of the members to the health of the city and prevalence of enteric fever.

Dr. Powell was requested to prepare a paper for the next meeting on "*Complications of Enteric Fever*."

CANADA

Medical and Surgical Journal.

MONTREAL, NOVEMBER, 1883.

THE STUDY OF ANATOMY.

The Provincial Legislature, at its last session, passed an Act to regulate the method of supplying our medical schools with subjects for purposes of dissection. The immediate reason for the passage of this Act was the occurrence of almost daily scandals during the past winter, owing to the body-snatching carried on in numerous parishes around this city. The sense of propriety of the entire community was outraged by this repeated desecration of graves and vaults, friends and relatives made loud complaints of the injury to which they were thus subjected, and the press teemed with allusions to the exciting topic and called upon the Government to see that steps were taken to put a stop to it. The "Anatomy Act" already in existence had proved quite inoperative and had been allowed to become a dead letter. Its provisions were essentially the same as the present one, but owing to the absence of a penal cause, it could never be enforced. Action on the part of the executive was clearly called for; they owed it to themselves and to the country to see that such a crying evil should be arrested. The subject was one which had been successfully legislated upon in other countries and it was a disgrace to our civilization that such a state of affairs should continue in our midst. After due consideration, therefore, and after having taken the advice of those best acquainted with the working of these laws elsewhere, the present Act was presented to the House and became law. It was received with great satisfaction by all the medical schools, and by the general public. We are not aware of any protests having been urged against its provisions during its passage through its various parliamentary stages. Quite recently, however, considerable stir has been created in this city and attention re-directed to the subject, owing to the action of certain of the authorities of some of our charitable institutions. The chief provision of the law is to the effect that every establishment which receives Government aid comes within the operation of

the Act; and it provides that, in the event of the death in such institution of a person without *bona fide* relatives who have claimed his body for burial, the Inspector of Anatomy shall be notified, and shall dispose of such body for educational purposes. Father Dowd, on behalf of the St. Patrick's Orphan Asylum and some of the directors of the Protestant House of Industry and Refuge, have opposed the working of the law in their respective establishments. The former, we are bound to say, has taken the only logical course, *i.e.*, has renounced the Government grant. Thus, then, the law no longer refers to the asylum mentioned. But a number of the governors of the House of Industry appear desirous of keeping the grant but evading the law. We regret very much this action on their part. The law is an absolutely necessary one in the interests of the peace of the whole community. They must know the scandals, the angry words and deeds, the heart-burnings, the police-court trials, the disgraceful traffic in bodies, that preceded the passing of this salutary Act. They must know all this. Now, the question is, do they wish to revert to that state of things? If not, will they please show us how a better arrangement could be made for supplying our dissecting rooms. They know these rooms *will* be supplied, legally if possible, illegally if not otherwise. The law guards carefully the disposition of the remains of those who have relatives—these have a natural right, no one can interfere with this. The remains of those who have no relatives, the waifs and strays, the law undertakes to dispose of, and in no other conceivable way can scandal be avoided and the reasonable demands of anatomical teachers complied with. We hope that the better counsels of some who addressed the meeting will yet prevail and that the opposition of this important body may be withdrawn. We would remind the gentlemen of the "House of Industry" that one of the greatest of our public charities has long faithfully submitted to the provisions of the old Anatomy Act, and, in not one single instance, has any dispute, scandal, or trouble arisen therein upon that score.

OUR PROVINCIAL LICENSE EXAMINATION.

Last month we took occasion to say something upon the present mode of conducting our Provincial Medical Board. Unseemly haste would appear to be the leading feature in the proceedings of that which should be a deliberative (and therefore necessarily deliberate) body. In nothing is this so marked as in the way in which the examination of candidates for the license is got through with. The instant the few short minutes

allowed by law for this purpose are at an end, a hurried conference of the examiners is held and a verbal report of the result conveyed to the President. There is a section of the law which reads: "Each member of these sub-committees (examiners) shall * * * * register his vote *with his initials* immediately after the examination." This is a very proper provision, as it constitutes a written record for reference in the event of any possible dispute. At the last meeting, at any rate, this certainly was not done.

If any one will take the trouble to compare the two examinations conducted by this Board—the Matriculation or Preliminary, and the Professional—they cannot fail to be struck with anomalies that present themselves at once. In the former the examination is both oral and written, in the latter oral only. In the former it is thorough and efficient, in the latter it is superficial and hasty. The former is conducted by gentlemen specially selected for their long experience in teaching and in examining pupils, the latter is conducted by examiners chosen almost at hap-hazard from a body of general practitioners without any reference to their possessing experience in teaching or in examining students. The former extends over two days, the latter (for each student) cannot exceed one hour and forty-five minutes. But the singular thing about it is, that the former—the long, searching, written and oral examination, conducted by well-known specialists—is only to find out if a young man knows enough to be allowed to begin the study of medicine: whilst the latter—the hasty, superficial, oral examination conducted by random-chosen examiners—is to determine whether or no the candidate is well versed in all the important branches of practical medicine and surgery, and whether he shall receive the License to practise in this Province.

Fortunately for the Province, the great majority of those who are licensed are holders of diplomas from our Universities, all of which are, in greater or less degree, endeavouring to raise the standard of medical education by the honesty and severity of their examinations. Now, we do not consider that the examination for the License should be of as high a grade as that for the M.D. from an University, but we do think that some advance should certainly be made in the character and procedure of the license examination as now enforced in this Province. It matters not how few the candidates are, so long as the Board retains the power of examining for a License, it should certainly not fail to make that examination at least as imposing and effective as that which it insists upon as preliminary to the commencement of study. Why should this matter not be discussed

by the Board? If they could see their way to having an *annual* meeting *only* (as we have already advocated), we believe it would be a step in the right direction. Let examiners be chosen from the members of our teaching bodies in the Province (not necessarily members of the Board), and let them be selected as having special experience in particular branches; let them meet the candidates two days before the meeting; let there be a fair written as well as oral examination; let them hand in a written report of the results; and we venture to say that the License for this Province will soon gain the respect of the entire medical community. As it is now, we know that such is not the case.

THE HARVARD CENTENNIAL.

Wednesday, the 17th of October, was a red-letter day in the history of Harvard Medical Faculty. Not only was it the celebration of its entrance upon the second century of its existence, but, by the liberality of the citizens of Boston, it was enabled formally to take possession of a building worthy in every respect of the purposes to which it has been dedicated. The exercises of the day began in the hall of the School of Technology, when Dr. Oliver Wendell Holmes, the Emeritus Professor of Anatomy, delivered one of his most characteristic addresses, dealing chiefly with the past history of the school. To the many strangers present, this was the event of the day; it was, indeed, a rich treat. It is sad to think that "haggish age" is fast creeping on the genial Professor, but though showing his years more than when we last saw him, he is still vigorous and active, and looks as if he meant to keep the great Autocrat at bay for some time to come. After the address, a portrait of Dr. Holmes was presented to the Faculty and also a bust of Dr. Bigelow, the Emeritus Professor of Surgery. The dedicatory services were held in the new building, and consisted of an address on behalf of the donors by Col. Lee, and a suitable reply by Dr. Williams. Luncheon was then served after which the visitors inspected the classrooms and laboratories. The building is situated on Boylston street, in the best part of Boston, close to the Art Museum and other large public buildings, with which it bears comparison very favorably. It is a handsome brick structure, faced with stone, four stories high, and 120 feet front. The internal arrangements are in the most modern style and surpass anything of the kind on the continent. The Chemical, Anatomical, and Physiological Laboratories take up a large section of the building and are splendidly adapted for work. It is a very proper

thing, indeed, that Harvard School of Medicine should have such exceptional accommodation for her students and such facilities for teaching. The Faculty have led the race in reforming the lax and imperfect system of medical education which prevails in the States, and have set an example which has been followed closely by some schools, while many others have been not a little benefited. The change from the old two course system in 1871 was a very serious one; many thought it would be fatal, but the lengthening of the course to three years, and the session to nine months, with entrance and sessional examinations, while reducing the number of the students has proved a great success. The increase of the fees has much more than compensated in income for the falling off in numbers while the quality of the students has greatly improved. In 1870-71 only 23 per cent. of them held academic degrees; last session over 50 per cent. were graduates in arts. The extra-fourth session, at present optional, is taken by an increasing number and will soon be made compulsory. It was gratifying to find the Dominion well-represented on the occasion. From Montreal were Drs. R. P. Howard, F. W. Campbell and Osler; from Toronto, Dr. Aikens, the President of Toronto School of Medicine; from Hamilton, Dr. Mullin, President of the Canada Medical Association, and from Fredericton, N. B., Dr. Atherton. To anyone interested in higher medical education, we would recommend a trip to Harvard.

THE HALIFAX ABORTION CASE.—So far as we can learn, the facts of this lamentable occurrence were as follows: a widow named O'Connor, in comfortable circumstances, became pregnant and consulted Dr. Lawson, with reference to the procuring of abortion. According to the deposition, the Doctor told her that instruments would have to be used and he would charge her \$50. The operation was performed and two or three days after the woman had a miscarriage, followed by puerperal septicaemia and death. The *post-mortem* did not reveal any signs of instrumental violence. A coroner's inquest was held and the following verdict returned, "That Bridget O'Connor came to her death by abortion practiced by Dr. Archibald Lawson with criminal intent." On hearing of the woman's death and the nature of her dying deposition Dr. Lawson left the city. Dr. Lawson was one of the most prominent members of the profession in Halifax, and lecturer on the Principles and Practice of Medicine in the School of Medicine.

THE GENERAL HOSPITAL.—At the quarterly meeting of the Montreal General Hospital, held on the 14th instant, it was announced that this institution had received from Geo. Stephen, Esq., the munificent donation of \$50,000. The donor stipulates that a wing for surgical cases shall be built in memory of the late Dr. G. W. Campbell, and that wards therein shall always be at the disposal of the Professor of Clinical Surgery in McGill University.

—One of our Canadian cities (not at all the largest) boasts an unusual number of advertising specialists. Their cards, as presented in the daily papers, present the usual ingenious devices for attracting attention. One, however, whose card has been sent us by a friend, gets ahead of all his *confrères*. On the back of the ticket which announces that the diseases of infancy and childhood are his *forte*, we find the following which we copy for the benefit of those who want a tip :

To _____

Having derived GREAT BENEFIT from the Medical Treatment of Dr. _____ I RECOMMEND you to secure his services.

Signed, _____

We only omit the name because we cannot afford to give free advertising.

Obituary.

DR. TRUDEL.—By the death of Dr. E. H. Trudel, Montreal has lost one of its oldest and most respected physicians. Although ailing for some years, he had, up to a short time ago, been able to attend to his duties, and his death, which took place on the 5th inst., was in a manner unexpected. Born in 1820 at Ste. Genevieve de Batiscan, he received his preliminary training at the Nicolet College, and began the study of medicine under Dr. Kimber of Three Rivers. Proceeding to McGill College in 1841, he graduated in 1844, with six others, in the same class with the late Dr. Scott. Only two of his classmates remain—Drs. Godfrey and Proulx of this city. He began practice in Montreal, and early joined L'École de Médecine, and became Professor of Midwifery. In 1872 he was elected President of the School, and continued to take an active part in its management up to the present session. For years he was on the staff of the Hotel Dieu, and gave clinical instruction to many generations of students. A careful practitioner, a courteous colleague and a good citizen, Dr. Trudel has left behind him a faithful record and a memory which will long be cherished in the community.

DR. MARION SIMS.—This eminent and well-known surgeon and gynæcologist died suddenly of heart disease in New York on the 13th inst.

WM. MCGILL, M.D., of Oshawa, died on the 9th inst. He was a graduate of McGill College in 1848, enjoyed a very extensive practice, and also took great interest in politics. He was for some time the local representative for Ontario, and was one of the early members of the Ontario Medical Council.

—We regret to hear of the death of Dr. Weiss, of Vienna, a Privat-Dozent of the University, and well known to many American and Canadian students as an excellent teacher in General Medicine and Nervous Diseases.

—Surgeon General Crane, U. S. Army, died on Wednesday, Oct. 10th, of hemorrhage of the throat, after serving a little over a year in his new position. He entered the army in 1848. His successor has not yet been appointed. Efforts are being made to induce the Government to appoint Dr. Billings, who is undoubtedly the man for the position.

Personal.

C. M. Gordon, M.D. (McGill, '81), is practising at Aylwin, Que.

We regret to hear that Dr. F. W. Campbell was thrown from his carriage on the 10th and badly shaken.

J. J. E. Maher, M.D. (McGill, '83), has been appointed one of the District Dispensary Physicians in New York.

Dr. Ogilvie, of Kingston, Jamaica, President of the Local Branch of the British Medical Association, spent a couple of weeks in town last month.

We were pleased to have a visit last month from Hamilton Allen, M.D. (McGill, '72), of Ocionto, Wis. He is one of a large number of prosperous Canadian doctors in the Western States.

John Brodie, M.D. (McGill, '77), of Honolulu, has returned for a short visit to his friends. He gives an excellent report of the Island, where he has prospered during the past three years, as did his predecessors and friends, Drs. Vineberg and Miner.

J. B. Lawford, M.D. (McGill, '78), M.R.C.S., Eng., has been appointed House Surgeon at the Royal London Ophthalmic

Hospital, Moorfields. Dr. Lawford has been acting as Assistant to Mr. Nettleship at St. Thomas', and has been making steady progress in his professional career in London. He is the third Canadian within ten years who has held this important position. Dr. Buller, of Montreal, and Dr. Burnham, of Toronto, were predecessors.

Medical Items.

—A medical weekly, called the *Clinical and Pathological Journal*, has been started in Edinburgh. It was quite time.

—Henry J. Rogers, one of Souvielle's peripatetics, has been in the clutches of the law in St. John, N.B. The new Medical Act of that Province seems a good one.

—Our English exchanges contain a full account of the removal of Harvey's remains from the vault at Hempstead to the chapel, where a special marble sarcophagus had been prepared.

—The Medico-Chirurgical Society of Montreal proposes to undertake the collective investigation of facts relating to typhoid fever. The necessary cards will be issued in a week or so.

—A cable to the *New York Herald* from Rio states that a physician of that city has cultivated the microbe of yellow fever and is successfully vaccinating persons, who then get the disease in a mild form.

—There are 68 new entries in the Medical Faculty, McGill College. From Ontario, 40; Quebec, 17; New Brunswick, 6; United States, 2; Nova Scotia, 1; West Indies, 1; Manitoba, 1. There are over 200 names on the register.

—The Public Health Convention of the United States met in Detroit on the 13th. Several Canadian health officers were present. Dr. Oldright, President of the Ontario Board of Health, read a paper on "Overhead Ventilation of Drains and Sewers."

—Dr. Henderson, of Calgary, N. W. T., writes that he was then, Oct. 11th, attending Dr. Paul Cameron (McGill, '82), for a severe attack of Typhoid. Dr. C. had been practising at Medicine Hat. His brother, Dr. J. D. Cameron, of Iron Mountain, Mich., had come to visit him.

—The Koch cholera mission which has been at work in Egypt, has obtained permission to proceed to India to continue the investigation of the disease. It appears doubtful if the bacillus which has been found in the intestine is the *right* one, and further search is needful.

—The *Canada Lancet* states that Dr. Joseph Workman has been elected an honorary member of the Phreniatric Society of Italy. We are glad to see that his labors are appreciated by his Italian colleagues, whose writings he has so often introduced to us by excellent translations.

—The *Medical News* states that in three days thirty cases of Typhoid were admitted to the Montreal General Hospital. On enquiry we find that the admission has never reached that number in the time mentioned, and the statement has probably had its origin in a newspaper *canard*.

—Before leaving Canada, His Excellency the Governor-General and H.R.H. Princess Louise presented a very handsome despatch-box to Dr. Grant of Ottawa, who had been their physician. We understand that Dr. Grant has been notified to consider himself the medical attendant of the present incumbents of Rideau Hall, Lord and Lady Lansdowne.

MCGILL MEDICAL SOCIETY.—The fortnightly meetings are largely attended this session. On October 20th, Dr. Osler read a paper "On the Duties of the Physician as Examiner in Life Insurance." Dr. Mullin, of Hamilton, Ont., the chief medical officer of the Canada Life, was present, and gave a most interesting address on the subject, full of valuable suggestions. On the 3rd ult., Mr. Wyatt G. Johnston read a paper on the "Causes of Death in Typhoid Fever," based on the records of about 50 autopsies recorded in the post-mortem books of the Montreal General Hospital.

—The Curator of the Museum, Medical Faculty McGill University, begs to acknowledge the receipt of the following specimens during the past month:—

From Dr. Harkness, Irena, Dundas Co.: "An Anencephalous Monster."

" Dr. T. L. Brown, Melbourne, P.Q.: "Periosteal Tumor of the Bones of the Pelvis."

" Dr. Mullin, Hamilton: { "Tumor of the Penis."
"Tumor of Female Urethra."

" Dr. And. Henderson, Calgary, N.W.T.: "Femoral Artery accidentally divided without injury to the vein."

" Drs. McLean and Duncan, Fergus Falls, Minn.: "Maggots from External Auditory Meatus."

" Dr. Phelps, Chateauguay, N. Y.: "Cancer of Liver and Portal Lymph Glands, with Thrombosis of Portal Vein."

" From Mr. Bancroft, Veterinary Student: "Cyst on Mitral Valve of Cow."