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CANADA

MEDICAL & SURGICAL JOURNAL

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Original Communications.

CYSTITIS.

A LECTURE DELIVERED ON MAY 17TH, 1884, BEFORE THE SUMMER SESSION CLASS IN GYNÆCOLOGY, MCGILL UNIVERSITY.

By WILLIAM GARDNER, M.D.,

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

Gentlemen,—The subject of the lecture for this morning is, if judged by its frequency and the amount of distress it causes the unfortunate sufferer, one of the most important that can engage our attention. You will meet with it in a great variety of circumstances, and unless you are forewarned, you may, perhaps, diagnose the disease when it is not actually present.

While in some respects the disease resembles cystitis in our own sex, it differs from it in many others. These differences refer mainly to the causation, as influenced by that important adjacent organ, the uterus, with its remarkable functions and the many diseases to which it is subject. This is neither the time nor the place to enter into a detailed consideration of cystitis in women. Those of you who may wish to pursue further the study of the subject, I refer to Skene's work on the "Diseases of the Female Bladder and Urethra," and Winckel's Treatise in Billroth's *Handbuch der Frauenkrankheiten*. I purpose, therefore, to consider it in some of its more practical aspects as it presents itself to the practitioner. It is divided into *acute* and *chronic*. It may affect each or all of the coats of the bladder, and so be of the *mucosa*, of the peritoneal investment, or of the muscu-

lar coat. But these are often steps in a general process, the disease beginning in the *mucosa* and extending to the other coats, and this is the most frequent order, or beginning in the serous coat, as an epicystitis or pericystitis, and extending inwards to the mucous coat, which is much rarer. The causes are many. Injuries from blows, falls, coitus, sudden displacement of the uterus, fracture of pelvic bones, pressure of the child's head during labor, over-distension of the organ after labor or under other circumstances, rough catheterization or frequently repeated gentle use of the catheter, introduction of foreign bodies as practised by masturbating and hysterical women, abnormal urine, and extension of inflammation from adjacent organs, as of gonorrhoeal or simple vaginitis or vulvitis, or from the peritoneal surface. A little more extended consideration of some of these causes will be profitable. The pregnant, parturient, and recently-delivered woman, in whom the parts are in a condition of physiological activity and of increased vascularity, or have undergone contusion from pressure, or are paralyzed, and so liable to over-distension, is especially prone to cystitis. Hence the great frequency of the disease under such circumstances, and its unusual difficulty of cure. Of catheterization, it must be said that it is always a source of irritation, however gently performed. How much more-so must it be if done roughly, and if the necessity be frequent. But there is another source of danger in the use of unclean catheters. Winckel has said that the mucous membrane of the bladder is the most sensitive in the body, to sepsis. These facts convey to you self-evident and important cautions.

Abnormal urine is most important in its effects in causing inflammation of the mucous coat of the bladder. Probably, however, it is not so powerful if the mucous coat be healthy. Congestion, as from over-distension, furnishes a sufficient predisposition. Women frequently suffer from over-distension of the bladder in conditions other than puerperal. "The Relation which Faulty Closet Accommodation bears to the Diseases of Women" is the title of a lecture, on a somewhat unsavoury subject, by the eloquent Goodell of Philadelphia. For such reasons and others, women often delay emptying the bladder for a long

time after there is a safe amount of distension. Many cases of cystitis are thus set up in the sex. Now let us see how such a cause may act. Over-distension of the bladder means congestion. Over-distension leads to deficient power to expel the last drops of a urine which, from the congestion, contains mucus. The mucus decomposes. It sets up decomposition of the urea, and carbonate of ammonia is produced. This renders the urine alkaline, and therefore foreign and irritant to the coat of the bladder. Another result of alkaline urine is the precipitation of the earthy and triple phosphates, and so inflammation is set up.

The symptoms of cystitis are well marked. Frequent and painful micturition, accompanied with tenesmus of the bladder. The pain, at first local—pelvic and perineal—radiates to the navel or the breast and loins. The urine, at first pale, of low specific gravity, and acid, becomes alkaline and turbid from blood, mucus, pus and precipitation of phosphates. The disease is not always confined to the bladder. It may extend up the ureters to the kidneys, and so ureteritis, pyelitis, pyonephrosis and renal abscess result. In the bladder itself, a cystitis, at first merely catarrhal, may become ulcerative, or the inflammation may be diphtheritic or gangrenous.

The diagnosis is usually easy, but it cannot be made from the symptom of frequent and painful micturition. The urine must contain mucus, blood or pus. The conditions with which it may be confounded are irritation of the bladder from uterine displacement; irritation or inflammation, with cicatrization of the utero-sacral ligaments, other forms of pelvic peritonitis, fissure at the neck of the bladder, urethritis, and stone in the bladder. As regards most of these, it may be said that to be forewarned is to be forearmed.

The prognosis is much better than it would have been twenty years ago. In healthy subjects it is good. In the pregnant or lying-in woman, it is not so favorable. It is in such more apt to become chronic, and to leave the part weakened and sensitive. When ulceration is present, the outlook is by no means so favorable, although not absolutely bad. The tendency to hemorrhage, to extension to the peritoneum, to perforation, to extension to the kidney, to

blood-poisoning, constitute many avenues to a fatal result which sometimes comes to the patient when it is not expected.

The treatment, being suitable, ought to be early and prompt, to prevent the disease becoming chronic. When this stage has been reached, it will require the exercise of much of your own patience, as well as that of the sufferer. In the acute stages, keep her at rest in bed, keep the skin acting, and also the bowels, by the use of saline laxatives or mineral waters, aided, if necessary, by cold water enemata. Indigestion must be removed, and a free portal circulation maintained. An important indication is to render the urine as bland and unirritating as possible. A diet of large quantities of skim-milk, diluted, in cases where the urine is very acid, with some natural alkaline water, as Vichy or Apollinaris; but the supercarbonated potash water made by Chas. Gurd & Co. of this city, and the ærated water of the Caledonia saline spring, as charged by the same firm, are equal to any, and, of course, much cheaper than imported waters. Linseed tea and the decoction of *triticum repens* in large quantities act as diluents to the urine, and perhaps as something more, especially in the case of the latter. A good prescription in the early stages is a combination of citrate or bicarbonate of potash with infusion of buchu. From Sydney Ringer's prescription of drop-doses hourly of tinct. of cantharides I have had no good results, and cannot therefore recommend it. Leeches to the anterior vaginal wall, and poultices of linseed meal and tincture of opium to the hypogastrium, are often of undoubted value. To relieve the severe pain and distressing tenesmus, you will be obliged to give sedatives and narcotics, but I must caution you to withhold the most powerful of these, the opiates, as long as possible. They undoubtedly relieve pain, but they also derange digestion and act injuriously in other ways. By mouth, the Dover's powder is the least injurious. The rectal suppository is probably the most efficacious form for the administration of morphia or other remedies. Other remedies are, however, to be first tried. Camphor is useful. The bromide of potassium sometimes acts best. It must be given in full doses—20 grains every four hours. Skene speaks well of hydrobromic

acid. It may be given in doses of two to four fluidrachms of the dilute acid, well diluted with water. Marked alkalinity of the urine furnishes an indication not very easily met. The only acid useful for this purpose is the benzoic; the dose is 10 grains. A small dose, say 5 grains, of borax should be added to render the benzoic acid soluble. The combined dose may be given in infusion of buchu. In the later stages of this, as of other mucous inflammations, balsamic remedies sometimes do good. Balsam of Peru and of Copaiba, and oil of turpentine, are the most useful. In cases where there is markedly foetid urine, salicylate of soda has been highly commended. But the time soon comes, in cases at all severe, at which local applications to the vesical mucous membrane must be used, if we are to do the best for our patients. The simple washing out of the bladder is often of the greatest value; but the method of this simple operation is of the utmost consequence. If done carefully, so that the coats of the bladder suffer no mechanical violence, much good may be effected; otherwise it may be most injurious. As a rule, the piston or bulb syringe must be avoided. Use, then, a fountain syringe. The most convenient form is a small-sized glass funnel, with two feet of rubber-tubing attached, the other end of the tubing being slipped over the open end of a No. 8 gum-elastic catheter. Violent contact of the coats of the bladder as it contracts with the end of the catheter is often most hurtful. To obviate this, the catheter must be made to barely enter the cavity. To attain this, especially when the patient or her attendant (as must often be the case) administers the injection, slip over the catheter a guard, which may be a piece of thin, flat wood or gutta-percha perforated, leaving only $2\frac{1}{2}$ or 3 inches of the catheter from its point. The guard rests against the vulva and prevents the catheter penetrating more than is necessary to just enter the cavity. With such a simple cheap apparatus, which any one can prepare in a few minutes, every object may be attained in the majority of cases. Gravity is the injecting force. It is even, not jerky, and may be as gentle as desired, according to the height of the funnel. The patient being placed on her back, with the knees drawn up, the catheter is inserted,

and without removing it, the bladder may thus be thoroughly washed out, and the cleansing fluid having been allowed to flow out, the medicated solution is run in. To avoid irritation from over-distension, no more than, at most, two fluid ounces ought to be injected at once. This is a point on which Sir Henry Thompson is most emphatic in his instructions for injecting the male bladder. It is equally important in the female. Next, some instructions as to the solutions you are to use. For mere washing-out purposes, solutions of common salt or of potassium chlorate are best— $\frac{5}{i}$ to the pint. These solutions are less irritating than plain water. Carbolic acid, 1 to 60, is also valuable. Then there are various astringents which sometimes are beneficial. Such are acetate of lead, sulphate of zinc, and tannic acid, one or two grs. to the ounce. Of this class of remedies, I have reserved for last that which, in my opinion, is the most valuable—the nitrate of silver. You will find, by most writers, solutions of 1 to 2 grs. to the ounce recommended. This is far less valuable than a much stronger solution, 30 or 40 grains to the ounce, of which I have had some recent very satisfactory experience. Such a solution causes severe pain and vesical tenesmus for a few minutes, and it is well to be prepared with your hypodermic syringe when administering it, which usually must be at the patient's own home. Confinement to bed for a day after is advisable. I may here mention a case I recently saw. The symptoms were of several years' duration, and came on after confinement. During nearly a year I had tried a variety of astringents, with only slight benefit, but my attention was directed, during the winter, to the stronger solutions of silver nitrate by an article in the *Philadelphia Med. News*. I resolved to try the remedy. The results were most satisfactory. After two applications, the patient expressed herself as being better than for eight years. In this strength, the remedy ought not to be used oftener than once a week. Morphia has been injected to relieve severe pain. Solutions of 1 to 2 grs. to the ounce may be employed.

The value of rest, so well recognized in the treatment of surgical cases, and of medical cases, too, is no less in inflammations of the bladder than other inflammations. It is the difficulty of

attaining this which renders cystitis hard to cure. In some cases, especially when the urethra is not involved, this may be attained by placing a catheter in the bladder, and allowing it to remain there constantly, removing it twice daily only for the purpose of cleansing it. This is to be done by forcing a stream of carbolized water through it. When a catheter can be thus tolerated, it will be of great value. Some years ago Dr. John Goodman of Louisville, Kentucky, published a paper in the *American Journal of Obstetrics*, Vol. VII, page 413 (1874), in which he reported a series of cases in which the method proved most valuable. He used a short catheter with a bulbous extremity, which secures its retention within the bladder. The other end is provided with a flange, which prevents it slipping in. A piece of rubber tubing attached to the outer end conveys the urine to some convenient receptacle. I show you Skene's modification of the Goodman catheter. Another means of securing rest is by an operation which has been done rather frequently in recent years. I mean rapid dilatation of the urethra. I reported a case of severe chronic cystitis cured by this operation, in the *CANADA MED. & SURG. JOURNAL* for February, 1881. I had, however, a subsequent failure, but the case was a much worse one. At that time I did not know the value of the strong solutions of nitrate of silver, or probably I should not have done the operation, which has been followed in many cases by the deplorable result of permanent incontinence of urine.

Lastly, and, as I believe, the most valuable resource of all for securing complete rest of the bladder, an artificial vesico-vaginal fistula may be formed. This operation was first done by the late Dr. Willard Parker of New York for the purpose of drainage of the bladder, in a man. Dr. Emmet of New York justly claims priority in the performance of the operation for the cure of chronic cystitis in women. By it the bladder is placed completely at rest for the requisite length of time, and an opening afforded for the application of medicated fluids to the lining membrane. It is true that the patient becomes a sufferer from a distressing infirmity, but one involving much less suffering than the condition for which it was inflicted, and perfectly curable by sub-

sequent operation. If it be further remembered that it is the only mode of treatment which affords a chance of life to the sufferer from a disease which so often leads to death from extension to the kidney or otherwise, its justification must be complete.

REMARKS ON VARICOCELE AND ITS TREATMENT.

By T. G. RODDICK, M.D.,

Professor of Clinical Surgery, McGill University; Attending Surgeon to Montreal General Hospital.

(Read before the Medico-Chirurgical Society of Montreal, May 23rd, 1884.)

The condition known as varicocele, or varix of the spermatic veins, is so familiar to you all, that it is unnecessary for me even to refer to its symptoms, causation, or diagnostic characteristics. It is usually regarded as a trifling affection, and one deserving of little attention. To this view, however, I am disposed to take exception, although, in so doing, I know I am at variance with some of the most eminent authorities in surgery. Thus, in those admirable clinical essays of his, Sir James Paget refers to varicocele as the disease of the hypochondriac, and hence unworthy of serious consideration. He admits, however, that it can be troublesome, from the sense of weight and aching which sometimes attends it. He ridicules the idea that it ever produces atrophy of the testicle. The writer of the article on Varicocele in "Holmes' Surgery" quotes Paget largely, and is evidently of his way of thinking, although he states (and here I think he somewhat contradicts himself) that "where varicocele is very marked and of long duration, true and permanent atrophy of the testis may set in."

We have very strong evidence, on the other hand, to prove that this affection is not so trivial, but that for many reasons it often deserves and demands the surgeon's earnest consideration. Thus Mr. Curling, in his admirable work on "Diseases of the Testicle," writes: "Varicocele tends gradually to impair the nutrition and diminish the secreting powers of the testicle, hence the importance of not neglecting this complaint, though it may produce no painful symptoms. A softening and partial atrophy of the gland, coexisting with varicocele, has come under my

notice in numerous instances; indeed in nearly all the cases in which there was a decided dilatation of the spermatic veins on one side only, the testicle on that side was the smaller of the two." Barwell, who has had a large experience in such cases, believes that the testicle from which the varicocele springs "is not of much use." Erichsen states that varicocele is frequently accompanied by debility of the generative organs and a tendency to seminal emissions and much mental depression. But he points out another danger which attends the presence of varicocele, namely, rupture of one of the distended veins, an accident similar to the bursting of a varix in the leg. One case of this kind, reported by Erichsen, proved fatal from syncope. Van Buren and Keyes write regarding the disease in a somewhat similar strain. So I think it can be proved that varicocele in its more aggravated form is capable of inducing serious pathological changes in the testicle, and hence frequently demands surgical interference.

But even if these changes were not so serious—if it were only for the relief of the pain, dragging sensation, and mental worry which varicocele so often induces, operative measures would still be justifiable. Besides, a very small varicocele often debars the possessor from exercise needful to health, and is a frequent cause of disqualification from active service. I find that during the ten years ending 1853 some four thousand British recruits, or 70.5 per thousand, were rejected for varicocele—a greater number, indeed, than the rejections for hernia. Of French recruits examined in the ten years from 1850 to 1860, 20,550, or 10.05 per thousand, were exempted for varicocele. It must be remembered, however, that the standard of height in the French army is below that in the English, and it is a well known fact that varicocele is much more frequent in tall than short men, the reason being obvious.

I have alluded to the fact that the mental condition of many of those suffering from varicocele is peculiar. Its presence has often a most depressing influence, and I know few affections in which the attention of the person is so concentrated upon his malady as in this. The constant weight in the scrotum, and the

perpetual aching pain up the cord, into the groin and down the thigh, tends to direct his thoughts to his ailment, and his life is in consequence often rendered miserable. Howe relates a case where he operated on a man whose mind was rapidly giving way under the morbid influence induced by the presence of a varicocele. In twenty months after the operation he was quite well and able to follow his usual occupation. "Here," he says, "we have evidence of great good having been done, for not only has the varicocele been cured, but a mental state bordering on insanity has been checked, if not entirely got rid of."

I have thus attempted to prove that varicocele, in some persons at any rate, is not so trivial an affair, but actually demands operative measures for its relief, even if some risk has to be incurred in order to effect a cure. It must be remembered, also, that the necessity for operation does not depend so much on the size of the varicocele as on the symptoms it produces. Thus in varicoceles of large size, the pain and discomfort are sometimes very slight; whilst in others, comparatively small and insignificant, the distress is often very great. A patient, otherwise healthy, and about 40 years of age, consulted me two years since for varicocele. The varix was well marked, although not by any means of very great size, but the neuralgic-like pain from which the man suffered was almost unbearable. He was free from pain only when in the recumbent position. I prescribed all the ordinary anti-neuralgic remedies, both internally and externally, and secured for him a well-adjusted suspensory bandage. He was relieved for a time, but subsequently lapsed into his former condition. He now became desperate, and threatened self-mutilation if the organ was not removed. I consulted with my friend Dr. Fenwick, and we decided that, under the circumstances, castration was perfectly justifiable, and I accordingly performed that operation. The man would not submit to any half measures, such as an operation for the cure of the varicocele itself, as he argued that, in the event of its failing, he might be left in a worse condition than before. I may state that castration has been frequently performed under circumstances similar to those just related. Both Aston Key and Brodie report cases almost identical with mine.

Now, as to the *treatment* of varicocele, I am decidedly of the opinion that any or all of the palliative measures usually recommended should have a faithful trial, namely, cold bathing, the suspensory bandage, the truss, Wormald's silver ring, marriage, &c., but if these fail to remove the trouble, and the symptoms continue after a year or two, I do not hesitate to perform one or other of the following operations:—

The first is the least formidable of the two, and requires only an ordinary amount of skill for its performance. It is, in fact, Ricord's operation, with one or two trifling modifications. This operation, as you are aware, consists in the introduction, in opposite directions, of two loops of wire—one between the vas deferens and the veins, and the other between the veins and scrotum—the free ends being passed through the loops, so that when drawn taut, the latter completely encircle the veins and constrict them. The books recommend us to keep up the pressure on the veins by tightening the wires from day to day over a piece of cardboard or a pledget of lint. This, however, will be found to annoy the patient, and from frequent twisting the wire will sometimes break. I prefer, therefore, to attach a piece of rubber tubing to the wires on either side and pass this round the body. In this way the pressure on the veins is made more equable and constant, and the parts need not be disturbed for days together. In one or two of my earlier cases I experienced great difficulty in removing the wires after the lapse of ten or twelve days, and on one occasion was obliged to break the wire in order to extract it. Of late, however, I have practiced a little device which completely obviates the difficulty mentioned. This consists in attaching to the loop of each wire a short loop of the same material, by pulling on which at any time the main wires can be separated. I was surprised to find, in looking up the literature of varicocele the other day, that Mr. Tufnell of Dublin suggested this slight, but not unimportant, modification of Ricord's operation over twenty years ago, although I have not seen it referred to in any work on systematic surgery. An anæsthetic is seldom required for this operation, although, in the case of a delicate, nervous person, it may be well to give ether, the scro-

tum being made dependent by bringing the patient's hips well over the edge of a table. Where an anæsthetic is not used, however, the best is the standing position. The time required for the division of the veins or their complete closure varies from ten to fourteen days, depending on the age of the patient and the size of the varicocele. I may say that I have performed this operation now seven times, with one failure. In none of the cases was a single unfavorable symptom noticeable.

The other operation is a more formidable one, although not by any means difficult. It is one of the outcomes of Lister's teaching, and is not justifiable unless performed with the strictest antiseptic precautions, including the spray. It consists in making an incision about an inch and a half in length directly over the varicocele, and commencing about half an inch below the external abdominal ring. The veins are then carefully separated from the vas deferens by means of the fingers, ligatured with catgut above and below, and divided by scissors between the ligatures. A small drain, either of rubber or catgut, is placed in the wound, and two or three sutures applied. The parts should then be carefully enveloped in the gauze dressing, care being taken to prevent the urine from contaminating the wound. An anæsthetic should be given, the patient's hips being brought over the edge of the table, and slight pressure applied over the external abdominal ring.

I have here the notes of three cases on whom I performed this operation in the winter of 1882-3, but will not take up your time with the details. The first case was that of an unmarried man, aged 31, with a very large and painful varicocele. I ligatured the veins on Sept. 20th, 1882, and he was allowed to go about with a suspensory bandage (the wound being quite closed) on Oct. 6th, namely, sixteen days after operation.

Case 2nd, 29 years of age, married; varicocele not large, but very painful; operated Oct. 6th, 1882; progressed very favorably till the sixth day, when his temperature went up, and he remained feverish for a couple of days. No cause could be found about the wound for the symptoms. He subsequently progressed very favorably, and was well enough to leave his ward in the hospital on the seventeenth day.

Case 3rd, aged 24, married ; had had a slight hemorrhage after connection on one occasion ; varicocele large ; has not diminished in size, nor have symptoms abated since marriage, two years ago. Operation performed January 20th, 1883 ; recovery uninterrupted ; patient allowed about on the fourteenth day.

I had an opportunity of examining two of these cases some months after operation, and was pleased to find no trace of the varicocele, and there were none of the original symptoms present. For a month or more after the operation the patient should wear a suspensory bandage.

QUARTERLY RETROSPECT OF SURGERY.

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

Surgeon to the Montreal General Hospital ; Professor of Anatomy and Lecturer on Operative Surgery, McGill University.

Recent Operations on the Intestines.—Operations on the intestines, formerly so rare, are now of common occurrence. They are called for in cases of strangulated hernia, producing a gangrenous condition of the bowel, in cases of artificial anus due to strangulated hernia, and in cases of intestinal obstruction due to various causes, as constricting bands, tumors, intussusception, &c. As long ago as 1727, Ramdohr successfully removed two feet of intestine found in an inguinal hernia, and up to 1846 only 11 cases of resection were on record, resulting in seven recoveries, one artificial anus, and three deaths. This operation was not performed again (*Medical News*, March 15, '84) until it was revived by Lücke in 1873, and during the last ten years it has been performed many times. The operation consists in relieving the constriction, and if the bowel be gangrenous, drawing it out of the opening, excising the damaged portion and the attached mesentery, and then sewing the cut ends of the gut together, thus re-establishing the continuity of the canal, and returning the parts to the abdominal cavity. Most of the fatal cases reported died of peritonitis. Out of 67 cases, 21 were complete cures, 2 recovered with artificial anus, and 44 (65-67

per cent.) died. According to the writer in the *Medical News* of the above date, the following points should command attention :

1st, To prevent effusion, the lumen of the gut must be temporarily occluded. This may be accomplished by a provisional catgut or silken ligature, but this method is open to the objection of throwing the intestines into folds, which interfere with the proper insertion of the sutures. The occlusion may be effected with a clamp or forceps, or, still better, with the fingers of the assistants.

2nd, If gangrenous, a triangular portion of the mesentery should be removed, and the edges united by suture after the vessels have been ligatured ; if sound, it may be ligated in mass. In either case, the mesentery must not be separated from the bowel beyond the points of severance of the latter lest gangrene of the edges of the wound ensue. The gut should be divided at right angles to its axis, unless one end is smaller than the other, when the cut should be made at an acute angle.

3rd, The most important step of the operation is the insertion of the sutures, the material for which should be pure silk soaked in a solution of corrosive sublimate. The safest and most efficient mode of uniting the severed ends of the gut is what is known as the Czerny-Lembert suture. This consists of an inner row of stitches, which are inserted at the distance of one-eighth of an inch from one another, and which include all the coats of the bowel, and an outer row not so close together, each of which includes the serous covering only. If the mucous membrane protrudes too much, it should be cut off on a level with the muscular coat, but the inner stitches should not include it. The accurate approximation of the edges of the wound will be greatly facilitated if the first suture be inserted on the mesenteric side and the second at a point directly opposite. The intestines should be resected only through a sound and undistended portion beyond the seat of infarctions and effusions, as the chief cause of failure is the damaged condition of the gut in the immediate vicinity of the gangrenous portion.

Cases do as well after excision of eight or ten inches of intestine as after excision of two or three inches. Koeberlé

of Strasburg, on one occasion, removed six and a half feet successfully. The question arises, does the resection and suturing of the gut in gangrenous hernia present any advantages over attempting the formation of an artificial anus. Billroth, Dittel, Bergman and other German surgeons favor the latter course, but the writer in the *Medical News* thinks that those who resort to the operation of resection follow the proper course. If successful, the recovery is absolute; if it fails, and the patient survives with an artificial anus or fœcal fistula, his condition is not worse than if the operation had not been practised.

Dr. Porter reports a case (*Boston Med. & Surg. Journal*, May 15, 1884) where he excised a portion of intestine, including part of the ileo-cæcal valve, for the cure of a fœcal fistula. The patient had a right inguinal hernia at the age of eight years, and a similar condition at a later period developed on the left side. Three years previous to her admission to hospital, the hernia of the right side became strangulated, an operation was performed, a portion of intestine sloughed, and an artificial anus was formed in the right groin. Twelve days previous to entrance the hernia in left side became strangulated, and was relieved by operation. The resulting wound, which brought her to the hospital, was healed in two weeks, and then an operation for the closure of the fistula in right side was performed, which was unsuccessful. At the woman's earnest request, Dr. Porter operated for radical cure on Jan. 11, 1884. At that time the woman had two fœcal fistulæ, one above the other, in the right groin; these communicated. They were united by an incision which divided the lower margin of the abdominal ring and laid open the hernial sac; the incision was then prolonged, and exposed the whole sac, making a wound four inches long. The two fistulous openings in the intestine were an inch apart, and were connected by a cut made in a director. The opening in the bowel was then seen to be in the ileum and cæcum, just at their union. The finger could be easily passed into the large intestine, but not into the small, owing to cicatricial contraction involving the ileo-cæcal valve, the opening being only the size of a lead pencil. A dilator was used to enlarge the opening,

and then, with the finger in the opening, the bowel was dissected from the surrounding cicatricial tissue ; this necessitated a section of the abdominal muscles from the external abdominal ring outwards for about four inches. The cicatricial margin of the opening was then trimmed off, and the opening was found to involve about four-fifths of the calibre of the bowel. The edges of this wound were then approximated, but as one side was the small, and the other the large intestine, the edges would not lie smoothly. To obviate this difficulty, a longitudinal cut was made in the small intestine, forming an oval-shaped wound, which could be approximated accurately to the cut edge of the large intestine. The wound was then sewn up with silk sutures as follows : " The needle was entered about half an inch from the wound, penetrating the peritoneal layer, then traversing the muscular layer of the gut, and emerging one-eighth of an inch from the margin of the wound, having left the mucous layer untouched. The needle was then entered at the opposite side of the wound in a corresponding manner, traversing the middle layer, and emerging about half an inch from the wound. Ten sutures were introduced in this way. When these were drawn tight, they rolled in the free margin of the wound, thus bringing two serous surfaces in contact, and turning the cut edge into the interior of the bowel." The intestine was then replaced in the abdominal cavity after additional silk sutures had been placed between the previous ones. The abdominal opening was now brought together with silver wire, the sutures passing through the peritoneum and fascia of the deeper muscles, but not the skin ; the skin was united separately by silk sutures, a large-sized drainage-tube having previously been inserted into the cavity of the abdomen. The wound was dressed after Lister's method, and the operation was performed under the spray. The patient did well, and, with the exception of some high temperatures a couple of weeks after the operation, due to a small collection of pus about the wound, was quite convalescent when the paper was read.

At a recent meeting of the London Clinical Society, held May 9th, Mr. Clutton related a case of *Intestinal Obstruction successfully treated by Operation.* (*Lancet*, May 17th, 1884.)

A boy aged 10, who several times before had attacks of obstruction of the bowels, which always terminated in copious evacuations after enemata, was, on the present occasion, taken suddenly with vomiting and great pain in the abdomen. Opium and enemata proving of no avail, Mr. Clutton decided to operate. He was transferred to St. Thomas' Hospital, and after the administration of an anæsthetic, the abdomen was opened. A collapsed portion of bowel was soon found, and, on bringing it to the surface, a tight, ring-like cord could be felt and seen to be the cause of the strangulation. The band was clamped by two pairs of forceps and divided; each end was ligatured by catgut. After division of the band, the bowel was set free from its strangulation. The band, on examination, was found to have reached from the extreme end of a diverticulum to the wall of the same loop of bowel at a distance of six inches. The abdomen was stitched up, and the boy recovered without any bad symptoms. In the discussion which followed the reading of the paper, Mr. Treves said that Peyrot had collected 29 cases of intestinal obstruction treated by operation, only four of which were strangulations by Meckel's diverticulum. He himself had collected 50 cases, and the mortality was about the same, viz., eight, and thirty recovered. In cases of operation for strangulation due to diverticula, only about one in four recover. Mr. Treves also remarked that the pain of complete obstruction was continuous, as in only 5 out of 50 cases was it intermittent.

Dr. Angus McDonald (*Lancet*, Feb. 9th, 1884) reports a successful case of *Resection of several inches of the Small Intestine in the course of Abdominal Section for removal of an Extra-uterine Pregnancy*. On opening the abdomen, a loop of small intestine was found communicating with the foetal sac, and, in fact, forming the roof of the sac. The intestine was in a very unhealthy and friable condition, and in endeavoring to empty the foetal sac, Dr. McDonald injured the bowel. The piece of diseased and injured intestine, amounting in length to about six inches, was removed, and the cut edges of the two ends brought together with a continuous catgut suture, care being taken not to include any of the mucous membranes. The

stitches were put very close to one another. The gap made in the mesentery was also brought together by suture. A faecal fistula, which communicated with the peritoneum, was closed by freshening its edges and bringing them together with catgut. There was a good deal of hemorrhage from the cut end of the intestine and mesentery, but the stitching completely arrested it. The abdomen and foetal cavity were then sponged out, and a gutta-percha drainage-tube introduced into the wound, to the bottom of the foetal sac, and retained by deep sutures. The abdominal wound was stitched in the usual way. For some days the patient was very ill, faecal matter coming away by the side of the tube, but after a time improvement set in. The bowels from the first moved rather frequently. By the 30th day the drainage-tube was removed, and from that time everything went well. The patient made a perfect recovery.

Prof. S. D. Gross, in a paper read before the late meeting of the American Surgical Association (*Med. News*, May 3, 1884) on *Wounds of the Intestines*, remarked that the first foundation of a rational treatment of lesions of this kind was laid in this country in 1805 by Dr. Thos. Smith of St. Croix. His experiments, twelve in number, were performed on dogs. In 1812, Benj. Travers published a treatise entitled, *An Inquiry into the Process of Nature in Repairing Injuries of the Intestines*. His researches were more especially directed to the elucidation of penetrating wounds, and to the proper management of the bowel in strangulated hernia. Mr. Travers availed himself largely of experiments on dogs. After Mr. Travers, French surgeons gave much attention to this subject, and performed numerous experiments on the lower animals; among these surgeons were Amussat, Jobert, Lambert, Gély and Choisy. In 1843, Prof. Gross himself published an elaborate treatise on the subject, founding his conclusions on a series of seventy experiments performed on dogs. The author of the paper goes on to say that the diagnosis of wounds of the intestines is a matter of primary consideration. If the bowel has escaped through the wound, it will be easy to find the injured part by the egress of some of its contents, and so, also, when there is a

discharge of some of the fæces, &c., through the outer wound, although there be no protrusion of the intestine. But in cases of wounds by a narrow instrument, as a knife, dirk, or bullet, the bowel does not protrude, and the surgeon is uncertain whether it is wounded or not. The two principal signs which must guide us in these cases are tympanites and a discharge of blood by the anus. Tympanites is of great diagnostic value if it supervenes almost immediately after the wound has been received. It is always diffused, and never circumscribed. In connection with the probing of such wounds, Prof. Gross said "the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm by disturbing the relations of parts and thus endangering fæcal effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful information in regard to the direction and extent of the external injury." He said two leading indications are to be kept in view in the treatment of wounds of the bowel—the prevention of fæcal effusion and the occurrence of peritonitis. To prevent these accidents, the wound in the bowel, be it ever so small, should be closed by sutures.

Prof. Gross advised the use of the interrupted suture in all wounds of the bowel, whatever their extent or direction. A long, slender sewing needle, armed with strong, well-waxed silk thread, is to be preferred; the sutures should be placed not more than a line and a half apart and one line from the edge of the wound. The needle should be passed deeply through the wall of the bowel, instead of embracing the entire thickness. Prof. Gross, in his paper, held that ordinary sewing silk, well waxed, is much preferable to carbolized catgut, as the latter is liable to give way prematurely. The continued suture had afforded good results in Dr. Gross's experiments in dogs, but the objection to it is that it leaves the edges of the wound in an uneven and puckered condition, which interferes with rapid union. The suturing of the wound having been completed, the parts should be cleansed with a syringe charged with warm water and returned. When the bowel is wounded, but not prolapsed, owing to the

smallness of the mural opening, the external wound should be dilated and the bowel hooked up and sutured, cleansed, and returned. To prevent peritonitis, the abdominal muscles should be relaxed, the bowels locked up with opium, and nothing but a little pounded ice, or iced water, should be given for the first three or four days, and if much gastric distress, a little dry champagne. Oppression from gas must be relieved by injections of turpentine or assafoetida. If peritonitis ensues, it should be treated by leeches and full doses of opium. At the end of five or six days, a laxative of castor oil or sulphate of magnesia should be given.

Prof. Gross does not give any of his own cases, and it does not appear from his paper that he has had any experience in treating wounds of the intestine except in the lower animals.

Dr. Chas. T. Parkes, in his address on Surgery before the last meeting of the American Medical Association, treats of *Gunshot Injuries of the Intestines*. His conclusions, derived from a large number of experiments performed on dogs (*Medical News*, May 17, 1884), are as follows:—

1. Hemorrhage following shot wounds of the abdomen and the intestines is very often so severe that it cannot be safely controlled without abdominal section; it is *always* sufficient in amount to endanger life by secondary septic decomposition, which cannot be avoided in any other way than by the same treatment.

2. Extravasations of the contents of the bowel after shot injuries thereof are as certain as the existence of the wound.

3. No reliable inference as to the course of the bullet can be made from the position of the wounds of entrance and exit.

4. The wounds of entrance and exit of the bullet *should not be disturbed* in any manner except to control bleeding or remove foreign bodies.

5. Several perforations of the intestines close together require a single resection. Wounds destroying the mesenteric surface of the bowel always require resection.

6. The best means of uniting wounded intestine after resection is by the use of fine silk thread, after Lembert's method.

It must include at least one-third of an inch of bowel tissue, passing through only the peritoneal and muscular coats, never including the mucous coat. The everted mucous membrane must be carefully inverted, and needs no other treatment.

7. Wounds of the stomach, small perforations, and abrasions of the intestines, can be safely trusted to the continued catgut suture.

8. Every bleeding point must be ligated, and the cavity of the abdomen must be perfectly cleansed.

9. The stumps of the divided mesentery should be secured to the intestine at the site of the resection.

10. Primary abdominal section in the middle line promises the most feasible opening through which the surgical treatment can be accomplished.

Anæsthesia by the Administration of Ether by the Rectum.—

Dr. Mollière, in a note published in the *Lyon Médical*, April, 1884 (*London Med. Record*, May-15th, 1884), states that at the suggestion of Dr. Axel Yversen of Copenhagen he administered ether by the rectum to several patients. In the first case the ether was thrown into the rectum by means of a Richardson's syringe. In five others, an India-rubber tube the size of the finger was introduced into the rectum and put in communication with a bottle containing ether. The bottle was placed in warm water (50°C.), and the vapor of ether gradually passed into the rectum. Whenever tension of the vapor reached a certain point, part of it escaped through the anus. After five or ten minutes the patients complained of drowsiness and a taste of ether in the mouth. Complete anæsthesia could be produced in this way, but it was generally found advisable to let the patient inhale a few grammes of ether. The advantages claimed for this method are the very small amount of ether needed and the absence of a period of excitement. Its advantages are of course obvious in those cases requiring operative procedures about the throat and face.

In the *New York Med. Record* for 3rd May, 1884, there are several reports of a series of cases where the rectal method of etherization was tried. Dr. Wm. T. Bull reports seventeen

cases where ether was thus administered. He does not find that, as a rule, the period of excitement is suppressed, and a much longer period is needed to produce anæsthesia than by inhaling. In most of the cases reported, the anæsthesia had to be completed by administration in the usual way. The patient, in nearly all the cases, experienced considerable distension of the bowel, and at the end of three or four minutes the odor of ether was detected in the mouth. In seven out of the seventeen cases the etherization was followed by diarrhœa, and the stools in two instances contained blood. Dr. Bull comes to the conclusion that ether administered in this way may be very dangerous, as it acts as a severe irritant to the intestines, and that, in old people or the very young, might cause death by diarrhœa and collapse. Five cases are also reported where ether was given by the rectal method in the service of Dr. Shradly at the St. Francis and Presbyterian Hospitals, New York. In one case only was there diarrhœa, and in two of the cases there was a period of excitement. The ether in all cases was administered for short operations, and a prolonged use of the anæsthetic was not necessary. On the whole, in this series of cases, the verdict is most favorable.

In the same number of the *Record* is a letter from Dr. Jas. B. Hunter, who reports six cases of rectal etherization, and says, as the result of this experience, that this method of administering ether is a radical improvement on the old one. The very small quantity of ether used, the absence of strangulation, and struggling or unpleasant sensations, are matters of no small importance, and give the rectal method a decided value.

At the very end of the journal above-mentioned comes the skeleton of the feast. This is a note of warning from Dr. Robt. F. Weir, who reports a fatal case in a child eight months old, who was operated on for hare-lip. At the close of the operation, the little patient was somewhat depressed, but rallied under stimulants; during the night, however, it had several large and bloody stools, and died the following morning.

That this method, when the mode of administration is better understood, will prove a most useful one in short operations on

the face, cannot be denied. It will also be useful as a preliminary to the usual method in cases where ether causes unpleasant sensations, such as strangulation and excitement, when inhaled. But, as Dr. Bull says, in the old, feeble, and very young, it may prove very dangerous by its depressant action and the production of bloody diarrhoea, as in Dr. Weir's fatal case. The amount required to produce anæsthesia by this method seems small, but the quantity given cannot readily be estimated or regulated. It will not suit in prolonged operations, except as preliminary to the method by inhalation.

Forcible Dilatation of the Cardiac Orifice of the Stomach for Stenosis.—Prof. Loreta, on the 15th of March last, performed, for the ninth time, dilatation of the orifice of the stomach. The case was one of a young girl aged 20, who had had ulcer of the stomach, followed by constriction, which had steadily increased. At first, solids, then fluids, entered the stomach with difficulty, the body rapidly wasted, and life could only be maintained by nutritive enemata. Having diagnosed stenosis of the cardiac orifice, Professor Loreta opened the abdomen in the linea alba, and found the stomach thick, small, and contracted. He incised it freely, and passed an elastic bougie through the cardiac orifice to make way for his dilating instrument. This soon overcame the obstacle in spite of efforts to vomit. The œsophagus was found much dilated. The apertures in the stomach and abdominal wall were sutured separately. The operation was performed under chloroform in 30 minutes, and the patient, so soon as she had recovered from the narcosis, to the great surprise of the on-lookers, swallowed three spoonfuls of water with perfect ease. The patient, when Prof. Loreta last wrote, had perfectly recovered.—(*Lancet*, April 26th, 1884.)

In an address *On the use of Opium as an aid to Surgery* (*Brit. Med. Jour.*, April 26, 1884), Mr. Geo. Pollock says it is in the various conditions of gangrene that opium may be said to stand alone as useful and powerful for good, whether the gangrene be the result of injury in old age, or whether it be in an ulcer in advanced life, kept open by neglect and exposure. In cases of gangrenous ulcers, opium administered internally

arrests or modifies any tendency to ulceration and sloughing, soothes pain, and husband the powers of the patient. In senile gangrene, Mr. Pollock knows nothing, as regards medical treatment, which can compare with the internal use of opium. It alone will mitigate the pain and render life tolerable till the line of demarcation appears. In such cases opium may be used freely. In traumatic spreading gangrene, opium is of no use; neither is it of any service in gangrene attendant on diabetes, or due to embolism. In the various forms of phagedœna, Mr. Pollock has seen most satisfactory results follow the free use of opium. In such cases opium is not so generally appreciated as it deserves to be, more dependence being placed on local than general treatment. Mr. Pollock has never once in his large experience had recourse to nitric acid in cases of sloughing phagedœna and sloughing sores, nor has he ever found the use of opium to fail in such cases. In all cases of syphilitic phagedœna in private and hospital practice he has trusted alone to the internal use of opium, and has never been disappointed. In ulceration and sloughing of the mouth in young children, Mr. Pollock has found ʒ minim doses of laudanum administered every four hours till drowsy, then omit whilst the drowsiness lasts, and continue after it ceases, of the greatest benefit; these cases getting well without any other treatment.

Of the use of opium after hernia operations, and in cancer, little need be said in praise. In cancer, it not only gives relief to pain, but renders life tolerable. The tolerance of opium in many cases is remarkable, the quantity being only measured by its quieting effects. In administering opium, constipation is a thing to be guarded against. Sir Benj. Brodie used to prescribe calomel occasionally when the continued use of opium was requisite. It will be sometimes necessary to relieve the rectum by enemata, and even occasionally to break down hard accumulations of fœculent matter. Not unfrequently opium disagrees in certain individuals; in one it may be the quantity, in the other the quality, of the ingredient. Some cannot take solid opium, whilst Battley's solution agrees well. In others Battley's fails, but codeia can be tolerated, especially as a sedative in bladder trouble complicated with enlarged prostate.

I have this winter had under my care a case of senile gangrene which fully confirms what Mr. Pollock says. First one foot became affected, and full doses of opium were given, the line of demarcation formed, and the gangrenous part removed; then the other foot became excessively painful, and soon after became gangrenous, and after some time a line of demarcation formed and this foot was removed. During all this time the patient was treated with full doses of solid opium to relieve pain, and 8 oz. of whiskey daily to sustain his strength. Without this treatment he would have succumbed to exhaustion; now he is in a fair way to recovery, having been supported by opium till the crisis had passed.

Pressure in the Treatment of Suppurating Buboës.—Prof. O. Petersen treats buboës, after fluctuation is clearly determined, as follows:—A large incision is made, and the cavity of the abscess is cleaned out with a sharp spoon. The bleeding is stopped, and iodoform powder is applied. Then comes the pressure bandage, which is the important factor of this treatment; its application is as follows: First a ball or wad of salicylic cotton, or other soft material made antiseptic by salicylic acid, is formed the size of the cavity and placed over it; upon this wad are placed several layers of the same material; then a second ball or wad, made of tow or oakum, and about four times as large as the first, is placed on this, over this oilskin or wax paper, and the whole firmly fixed with a gauze or elastic bandage. This bandage remains untouched for from seven to ten days. The average length of healing, in a trial of three years of this method, was twenty-three days; previously the average was seventy to ninety days. Twenty per cent. of the cases healed under one bandage, twenty-five under two, and twenty under three; more than seven bandages were in no case necessary. The average number of bandages was two.—(*Centralblatt f. Chirurgie*, Nov. 1883; quoted in *Practitioner*, April, 1884.)

I have used a somewhat similar treatment for the last two or three years, and have been well pleased with it. I have used borated cotton in place of salicylic. The pressure is the most important part of the treatment.

Iodoform in Erysipelas.—In an article in the *London Practitioner* for May, 1884, Mr. C. C. Burman states that in his experience the most successful external application for erysipelas is a solution of iodoform-collodion; it promptly relieves the burning pain and seems to arrest the progress of the disease, and in the cases where it was applied, there is a remarkable freedom from irritation during the period of desquamation. It is the experience of most surgeons that iodoform does not protect against erysipelas. I should imagine that in the cases referred to by Mr. Burman the good effect depended more on the collodion than the iodoform. However, it is a remedy worth trying. It probably acts in the same way as white lead painted on, viz., by protecting the inflamed surface from the air.

Cholecystotomy.—Mr. Lawson Tait (*Brit. Med. Jour.*, May 3rd, 1884), in a note on the above subject, states that the patient upon whom he first performed cholecystomy in 1879 is still living. He has performed the operation thirteen times, and all the patients have recovered. Mr. Tait does not approve of Sir Spencer Wells' suggestion that after opening the gall-bladder and removing the gall-stones the wound in the gall-bladder should be closed by a continuous suture without attaching it to the abdomen. It is, he says, a matter of extreme difficulty to be quite certain that all stones are removed from the duct, and if one remains, and the gall-bladder, which fills up with its own secretion even if no bile enter it, would, by its efforts to expel its contents, re-open the wound and cause extravasation into the peritoneum. The same reason exists for not putting into practice Langenbuch's proposal to remove the gall-bladder; if the gall-bladder were removed when a stone was lodged in the common duct, the bile must all flow into the peritoneum. In some of Mr. Tait's cases, biliary fistulæ have remained, some no larger than pin-holes. In one case, where a stone remains in the duct, every drop of bile comes through the fistula; he has several times tried to close the fistula, but without success, as the endeavor always brings on agonizing colic. In this case he proposes to open the abdomen again, about an inch to the inner

side of the gall-bladder, and to crush the obstructing stone *in situ* by means of a pair of padded forceps.

Whilst watching these interesting cases of biliary fistula, Mr. Tait has read much about the functions of the bile, and finds that all the experiments from animals have been futile in settling even the most elementary facts of the influence and uses of human bile. He has not seen the slightest evidence to prove that either quantity or quality of food, or any drugs that were used, as morphia, calomel, podophyllin and rhubarb, have the slightest effect on the quantity or character of the secretions. None of the patients have suffered even when all the bile came through the fistula—indeed, one patient gained in weight and greatly improved in health. The stools are almost milk-white, and there is not the slightest evidence of the flatulence and decomposition which is said in text-books to be the result of biliary fistula.

Reduction of Incarcerated and Strangulated Herniæ by Faradisation.—In *Vratch*, No. 23, 1883, Lev, Koltchevsky and Voloshkevitch report cases of strangulated and incarcerated herniæ reduced by faradisation, where taxis, warm baths, ether irrigations, &c., had failed. In some of the cases the reduction was accomplished in a few minutes; in others, in a quarter of an hour. One of the electrodes is placed alternately to the neck of the tumor and to the hypogastrium, and the other to the fundus of the hernia.—(*Lond. Med. Record*, April, 1884.)

Correspondence.

LETTERS FROM BERLIN.

(From a Special Correspondent.)

BERLIN, May 1st, 1884.

THE CONGRESS OF GERMAN SURGEONS.

The surgical congress which closed on the 20th ult. brought together a majority of the well-known surgeons of Germany, and has been in every respect a great success. The eminently scientific character of many of the papers, and the brilliant series of cases which were shown, told of the advanced position of German surgery to-day and of a combination of the *Science* and of the *Art* not to be found in every country. The congress opened on Tuesday evening, the 15th, with a reception in the Hotel-du-Nord. The regular meetings were held in the aula of the University and in the theatre of the surgical clinic. I shall give a brief account of the papers and cases which seem to me of general interest.

Dislocation of the Cervical Vertebrae.—Dr. Wagner of Königs-hütte (a mountainous and mining district) gave an account of five cases, showing two of the patients and several preparations. The first case, a man aged 50, was thrown from a railway carriage and fell on his neck. He was unconscious for an hour; paralysis of the legs and arms—latter not complete. Legs anæsthetic, trunk and arms with normal sensibility. Head bent strongly back; neck muscles tense. Slight passive movement of the head possible; no disturbance of deglutition. The next day the arms and trunk were anæsthetic. Examination under chloroform gave no positive evidence of the nature of the injury. Death took place on the third day. On the body it was impossible to find any alteration in the cervical vertebrae until after removal of the muscles, when the 6th was found dislocated forwards. The second case was that of a girl aged 15, who fell from a height of 18 feet. Complete paralysis and anæsthesia. Dr. Wagner saw her 14 days after. There was then extreme flexion of the head backwards, so that the face was directed upwards. Neck could not be moved much. The processes of

the cervical vertebræ could be felt ; that of the 6th was tender, and by careful palpation, crepitation could be felt. A diagnosis of fracture of this vertebra was made, and the head placed in suitable apparatus for fixation. Considerable improvement followed ; the paralysis began to disappear, but death took place after fourteen days from decubitus. The dissection showed luxation backwards of the 6th, with tearing of its ligaments. The next patient was a man on whom a stick of wood had fallen. On admission to the hospital there were paresis of the left arm and leg and of the detrusors, and great pain in the back of the head. The muscles of the left side of the neck were tense, and there was a marked projection to the left of the process of the 3rd cervical vertebra, and a decided irregularity could be felt in the pharynx. The reduction was effected by the Richet-Hueter method, and after fourteen days the starch neck-bandage was removed. The patient was exhibited, as well as photographs, showing the position of the head after the accident. The fourth patient, who had also received a blow on the neck, had much more severe symptoms. Complete paralysis of the legs, of the left arm, and of the detrusor vesicæ. Head turned towards towards the right. Examination under chloroform revealed no abnormality in the position of the processes which could be felt, only a greater sensibility of the 5th, and there was tension of the left cervical muscles. The diagnosis was rotation—luxation of the 5th vertebra to the left. The reduction was effected by turning the head to the right side and then bending it to the left and then to the opposite side. The luxation was reduced with an audible snap. The next day the condition of the patient was much improved, but it was not until two months that he began to get about, and even now there are signs of affection of the cord, as the left arm is wasted, flexed, and has tremors. In all other aspects, the patient, who was exhibited, appeared quite well. In the fifth case, a boy of five, fell on his head, and shortly afterward the mother noticed its remarkable position, but he complained only of difficulty of swallowing, pain and creeping sensations in the left arm. The head was bent strongly to the left, and when Dr. Wagner saw him, fourteen

days after the accident, examination showed a deviation of the 5th cervical process to the left, and a prominence also of the transverse process. From the pharynx there could be felt a projection of the body of the 5th, which was also twisted to the right. By strong bending to the left, and rotation to right, with moderate traction after three attempts, the reduction was audibly effected. The child recovered completely.

In the discussion which followed, Dr. Schede of Hamburg mentioned two cases of rotatory luxation. One, in a long-necked, thin man, occurred in a curious way whilst he was washing his neck very energetically, when suddenly the typical oblique fixation of the neck took place, which, in narcosis, was readily reduced. The other case was in a girl who fell off a rocking-horse : owing to the thin neck the luxation was easily diagnosed and readily reduced. There were no spinal symptoms in either case. Other cases were narrated by members. Dr. Wagner's preparations of luxations and fractures of the vertebræ were unusually fine. He has had quite an exceptional experience in these cases.

Fracture of the Odontoid process.—Prof. Küster of Berlin showed the patient, a young girl aged 18, and narrated the case. In January, 1882, her master had seized her by the hair and beaten her head several times against a beam. After this treatment she was seen to walk across the street. In the evening she complained of pain in the neck, and went to bed early. When she attempted to get up next morning she fell, and was found by her father in a convulsion, but conscious. She was put in a carriage and taken two miles to her home, and during the journey she remained stiff and speechless. She was paralyzed, could speak only with difficulty, and from time to time had convulsions. From March until September she remained without any special change. When admitted under Dr. Küster's care she lay stiff in bed, sensorium free, and she answered questions rationally, but with indistinct articulation. Pulse 120 ; breathing frequent, pectoral. Patient could only lift the legs a little. Reflex excitability extraordinarily increased ; sensation not disturbed ; bladder and rectum normal. When sat up in

bed the head fell forwards, the face became blue, and the breathing hurried. Examination showed that the process of the 2nd cervical vertebra was somewhat prominent, and there was an evident projection in the pharynx, just below the basis cranii. The treatment consisted in an extension of the head by a 10 kilogramme weight. In five weeks the result was extraordinary. The arms and legs could be moved freely, and the speech improved. A leather cravat was fitted to the neck, and she was allowed to go about. The improvement has persisted, and she was shown to the congress in good health. An evident projection of the 2nd spinous process still persists. The symptoms pointed to compression of the cord very high up, and the projection of the spine could be explained by three conditions: either fracture of the anterior part of the atlas, laceration of the transverse ligament, or fracture of the odontoid process. The uniformity of the projection in the pharynx was against the first view; tearing of the transverse ligament was very improbable, and had never been observed, and by exclusion, he concluded that the not very uncommon fracture of the odontoid process had taken place.

The question was raised as to the possibility of hysteria, but Dr. Küster thought that it could positively be excluded.

Transplanting Teeth.—Dr. Bidder of Berlin showed an incisor tooth which he had extracted on account of an alveolar abscess in 1879. Finding it quite sound, he cleansed the cavity and the fang with carbolic acid, and replaced the tooth. It stuck fast, and remained until 1882, three years, when it became loose, and at last fell out. The fang was almost absorbed by the granulations which existed in the socket.

The transplantation of teeth, of late years so much talked about, is in reality a very old affair. I have seen somewhere an advertisement, taken from a New York newspaper of about the year 1800, offering so much a-piece for sound and live incisors for the purpose of transplantation.

A new mode of Amputation at the Middle of the Foot.—Prof. Küster showed a girl, aged 4, whose foot had been badly crushed on the outer side by a waggon wheel. Gangrene fol-

lowed, and only the skin over the 1st metatarsal bone remained intact. In amputating at the tarso-metatarsal joints, he left the 1st metatarsal bone with the great toe, and, as the result proved, the girl has a very useful foot, and goes about quite well. The big toe has become strongly adducted.

Circular Goitre.—Dr. Credé, jr., of Dresden, showed a patient from whom, two years previous, he had removed a large thyroid which encircled trachea and œsophagus. The operation was performed on account of the attacks of dyspnœa; there was paralysis of the left vocal cord. For fourteen days after the patient had to be fed through the sound on account of difficulty in swallowing. In three and a half years Dr. Credé had, on twenty-two occasions, extirpated the thyroid, in two-thirds of the cases totally. In one case, a girl aged 16, death from meningitis followed, but as she had had a meningeal attack a year and a half before, it remains doubtful if the operation directly induced the fatal one. In the discussion which followed, Dr. Baumgärtner demonstrated several specimen of encircling goitre which he had removed, all successfully.

Primary Sarcoma of Spleen; Extirpation.—Dr. Hacker of Vienna demonstrated the specimen, which was removed successfully by Prof. Billroth from a woman aged 40, who had for ten years noticed a swelling in the left side. For two months before the operation it grew rapidly. The irregularity of the surface rendered a diagnosis of neoplasm probable. Part of the pancreas had to be removed with it on account of the strong adhesions. The interest of the case lies in the extreme rarity of sarcoma of the spleen.

Dr. Credé, jr., remarked that the patient from which he had extirpated the spleen in 1881 was now quite well and following his trade.

Dr. Czerny also stated that the patient from whom, five years before, he had removed a moveable spleen showed no blood changes, but had at times severe nervous symptoms.

Cachexia Strumapriiva.—Under this name Kocher describes the peculiar symptoms which in some cases follow removal of goitre. Dr. Baumgärtner of Baden-Baden stated that four of

his 19 cases presented these symptoms, the nature of which may be understood from the following history : A girl, aged 16, one year after total extirpation of a bronchocele, presented a great change in her expression. The face was puffed, and there was a general dullness of body and mind. These symptoms got worse within six months, and were accompanied by difficulty of breathing. Before the removal, there had been paralysis of the left vocal cord, which had improved after the operation. Within a year the rima became almost closed from paralysis of the abductors, and tracheotomy had to be performed. In all the cases, he supposed the trouble to be involvement of the recurrent laryngeal, not at the time, but subsequently, through the sympathetic (?) The general changes were probably brought about by the deficient oxydation of the blood. In some of Kocher's cases there was atrophy of the trachea—possibly from injury of blood-vessels of this part. The points in the operation which were specially insisted upon by Dr. Baumgärtner were the care of the recurrent laryngeal and of the tracheal blood-supply.

Hernia diverticuli intestinalis.—Meckel's diverticulum has on several occasions been found strangulated in the femoral ring. Dr. Busch of Berlin demonstrated a specimen obtained from a man aged 53, who had had for years a small rupture, for which he had worn a truss. At the beginning of the month he was attacked with great pain in the groin, with swelling of the abdomen, and signs of peritonitis. When brought to the hospital he was sinking fast. Nothing was found in the crural region to indicate a strangulation. The autopsy showed the abdomen filled with fæces and at the margin of a diverticulum on the ileum a small perforation. Dr. Busch supposed that the diverticulum had got caught in the ring, and the pressure of the truss had been sufficient to produce a small ulcer leading to perforation.

Ogston's Operation.—From the opinions expressed by many of the leading surgeons, this mode of operation is not much in favor ; indeed Prof. Ogston, who was present at the congress, has of late abandoned it. However that may be, certainly Dr. Partsch, one of the assistants at the Breslau clinic, presented a most favorable report on 23 cases operated upon from '78-'84.

Patients were all of the laboring class, and the disease had in no case originated in Rachitis, but in the pressure and strain entailed by the work. The ages ranged from 15 to 19. There was no change made in the operation. Spray was not employed. Photographs were shown of many of the cases, and four patients were presented, the results in which secured everything that could be desired. In the discussion, Professor Volkmann spoke strongly against the operation, while acknowledging the brilliant results obtained by Dr. Partsch. No one could guarantee that in a given case suppuration of the knee would not occur, and many instances of the kind had never been published. Just as good results, he thought, could be obtained by other and simpler methods.

Extirpation of the Larynx.—This operation has not been regarded by the profession with any great degree of favor. Any one who had the opportunity of seeing the patients presented by Drs. Hahn, Schede and Küster must have had any previous notions of the uselessness of the operation quickly dispelled. Dr. Hahn, Director of the Surgical Department of the City Hospital, Berlin, narrated five cases and showed three patients. The other two had died of pneumonia shortly after the operation. The first man shown had been operated upon $3\frac{1}{2}$ years before, and was now 71 years old, and appears quite well. The other two had only half the larynx removed, and the function of the organ was fairly well preserved; both could speak quite audibly. The statistics which Dr. Hahn gave of the operation were as follows: Of 52 total extirpations for cancer, 24 had died from the effect of, or shortly after, the operation, whereas of the 11, half operations only, one had so died. After the total extirpation, 14 relapses had occurred; after unilateral, only 3. Dr. Hahn operates as follows: An incision is made at a level of the hyoid bone, towards the diseased side, and from this another at right angles, in the median line, as far as the cricoid. After removing the soft parts, and tying vessels, the thyroid cartilage is divided, and an inspection made of the extent of the disease. If only half, then that part of the thyroid is cut out, and with it a portion of the cricoid and the arytenoid cartilages.

Dr. Schede of Hamburg presented a patient from whom, in 1882, he had removed half of the larynx for cancer. The most interesting feature of this case was the retention, in a high degree, of the function of the larynx, and the man could talk quite fluently, although in a monotone. With the laryngoscope, it could be seen that a sort of new vocal cord had formed on the diseased side. The recent statistics which Dr. Schede gave seem certainly to justify the operation, particularly the unilateral extirpation. Taking the 32 last operations, eight had died from the effects of the operation, six had recurrence of the disease within nine months, three had died of intercurrent affections, and fifteen still lived. The earlier it was recognized and extirpated, the better is the result.

Prof. Küster also showed a patient, a doctor, from whom he had removed half the larynx for cancer three years before. This man also spoke with wonderful distinctness.

Resection of a Cancer of the Small Intestine.—Dr. Schede of Hamburg narrated the case and showed the specimen. The patient was seen in May of last year, and presented symptoms of an abdominal growth, which could be felt to the left, just above Poupart's ligament. For some months there had been digestive disturbances and emaciation. The incision was made parallel to the ligament, and the abdominal walls were here found infiltrated, and, to the surprise of the operator, it was connected with the small bowel. It was removed, and the ends of the gut stitched together with silken continuous sutures. The patient made a good recovery, and in February of this year there was no sign of relapse. At the end of last month he was admitted with faecal vomiting, which was, of course, attributed to stoppage at the site of the former operation from return of the disease. The abdomen was opened for the purpose of making an artificial anus, when it was found to be an incarceration of the bowel by a ligament. This was cut through and the gut released, and on the same day patient had seven stools. Everything progressed favorably until the fifth day, when the man had a rigor and symptoms of apex pneumonia, from which he ultimately died. The specimen showed the healed intestine, with no sign of a

return. Dr. Schede remarked that the cases of resection for total obstruction had been very unfavorable. Of 19 such cases all had died; but, on the other hand, when done early, the results were extremely good. Of the 13, three had died of shock, and of the remaining 10, eight had recovered.

There were three other interesting specimens of abdominal surgery shown, but I did not see them; two by Czerny of Heidelberg, of resection of the stomach, and a case of gastro-enterotomy for stenosis of the first part of the duodenum, due to ulcer.

Wound Treatment.—Nothing very new on the subject was brought out. Dr. Bruns of Tübingen spoke of his continued success with the sublimated wood wool, the material now so much used in paper factories. It seems to make a very nice dressing, is soft, elastic, and very absorptive, and last, but not least, very cheap. Dr. Schede and Dr. Mikulicz (of Cracow) gave their experience with the sublimate—both very favorable, particularly the former, who spoke of its extraordinary protective power against erysipelas. Dr. Schede of Hamburg, who has one of the largest surgical clinics in the world, had not had a single case of the disease originate in his wards during the two years in which he has employed it. Dr. Leisrink of Hamburg showed prepared bog moss (*sphagnum*) for wound-dressing, with and without the sublimate. It seemed both dirty and dusty, and not to be compared with the fine wood-pulp, which is as soft as cotton-wool and very clean.

From 8 to 10 a.m. of each day the members visited the surgical clinics, of which there are five chief ones,—the Charité, Prof. Bardeleben; the University Clinic, Prof. Bergman (these are the clinics frequented by the students); the City Hospital, Dr. Hahn; the Augusta Hospital, Professor Kuster; and the Bethanien, Dr. Roser. The directors of the surgical department of each of these institutions is a permanent salaried officer, with, in some cases, fine quarters in the Hospital, and in all quite unrestricted as to private practice. Each one has from three to five skilled assistants, who remain with him for some years, and are usually among the aspirants for the surgical vacancies at the other German Universities.

The medical congress was held on the following week, and was also very successful.

The summer session, advertised to begin on April 15th, has only just opened. Punctuality is not a German virtue.

BERLIN, May 18, 1884.

THE KOCH DINNER, &C.

It must, indeed, have been a proud moment for the whilom district physician, Robert Koch, on the evening of the 13th inst., when some 500 of his brethren met to do him honor on his return from India and Egypt. The reception was, as remarked to me by one of the privat-docents, unprecedented and unparalleled in Berlin. It was, indeed, a gay festival. The guests assembled in the ante-room of the Hôtel-Central at 6.30 p.m., and a little before 7 o'clock Prof. Bergman, the chairman, entered with Dr. Koch, and the guests immediately adjourned to the winter garden of the hotel, where eight tables had been prepared. To the right of the chairman sat Dr. Koch, Prof. Virchow, Dr. Strücker of the Public Health Department, and Professors French, Leyden, Schröder and Bardeleben; to the left sat the two assistants on the commission, Profs. Dubois-Reymond, Hirsch, Volkman (of Halle), and Küster. Prof. Bergman, after greeting the guest of the evening, and congratulating the commission on its safe return, referred to the pride which all felt, from the Kaiser to the lowest citizen, at the fresh honors to German science which had resulted from the labors of Dr. Koch. "It was not," he said, "the courage with which you went forth to investigate the fatal plague which we admire. Many of those about me have done the same thing. He who (Virchow) went to Sperrath and Schliessen, to the typhus epidemic, threw his life on the hazard just as much as the man who examined the bodies of cholera patients in the dirty huts by the Ganges. Not one of us, indeed, would tarry a moment to think of our own health when the life of a patient is concerned. The device of our profession is that of the candle—'*aliis serviens ipse consumor.*'" "Nor do the consequences which are expected to follow blind us, as they do many who now cry 'hosanna,' thinking that there will be no more

cholera ; with us it is different. Our recognition of the value of your work would not have been changed in the least had the fatal disease followed hard upon your heels and entered Berlin with you." " We marvel, also, at the ceaseless industry of our colleague, who does not know how often the spirit of a country physician is broken, and his thinking powers weakened, by the endless round of visits. The reality of the waggon-rattle fits badly with the ideal of scientific work. But the district physician of Wollstein knew how to glean some hours from the restless and driving activity of practice, and, in the space of ten years, has concluded the series of brilliant observations from the discovery of the spores of the bacillus anthracis to that of the common bacillus of cholera."

These extracts will give but a feeble idea of Prof. Bergman's stirring address. Then followed two congratulatory addresses from the chief medical societies of the city, after which Prof. Virchow delivered a most humorous and characteristic speech. Dr. Koch's reply was extremely modest; he claimed only to have discovered improved methods of observation. He believed that one important result of the commission would be, if the English Government gave proper assistance, the limitation of cholera to its native place in India.

The Government has voted Dr. Koch 100,000 marks (25,000 dollars), and there is some talk of establishing a public health department in the University and making him Professor of Hygiene. Dr. Koch is about 40 years of age, a graduate of Göttingen I believe, and for many years was the district physician in Wollstein, in which position he made his earliest investigations, and began the improvements in methods which led to the discovery of the bacillus of tuberculosis. This feature of his career is particularly pleasing, and it reminds one of that other country physician who, nearly a century ago, made the memorable observations on cow-pox.

Reviews and Notices of Books.

A Treatise on Bright's Disease of the Kidneys : Its Pathology, Diagnosis and Treatment. With chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion.—By HY. B. MILLARD, M.A., M.D. With numerous original illustrations. New York: Wm. Wood & Co. Montreal: Dawson Bros. 1884.

The first forty pages of this work are devoted to a description of the anatomy and physiology of the kidney. The latest views on both these subjects are presented in a succinct, but yet complete, manner. One of the best chapters in the book is that dealing with the significance of the existence or non-existence of albumen in the urine, and the general conditions of its occurrence in health and disease. An account is given of Drs. Capitan and Chateaubourg's experiments and observations on the so-called "physiological albuminuria." These observers examined the urine of 94 apparently healthy soldiers five hours after a meal, with the following result: The urine of 76 (or 80 per cent) contained albumen. Forty of the 76 specimens of urine showed only a faint trace; the remainder, however, presented a well-marked cloud. Tauret's test (the double iodide of mercury and potassium) was the reagent used in testing these cases. It shows decided traces of clouding when both heat and nitric acid fail to do so. Albumen is also not infrequently present in the urine of children who are to all intents and purposes healthy. The influence of severe intellectual exertion in producing physiological albuminuria is shown by the observations of the two French physicians named, who found that the urine of 46 out of 50 pupils at one of the Government schools, who were hard at work preparing for examination, contained albumen. Cold bathing, sexual excitement, and menstruation have also an undoubted influence, according to the same observers, in making albumen appear in the urine. With the tests commonly used (heat and nitric acid) it is admitted by Millard that it is impossible to demonstrate the existence of albumen in anything like the same proportion of cases. He cautions against unnecessarily alarming a patient

simply because albumen has been found in his urine. He says that when albumen exists in the urine in such minute quantities as to be undetectable by nitric acid, it is not of much practical importance as indicating the existence of nephritis. The microscope is, in doubtful cases, the only reliable test whether nephritis exists or not. After detailing the causes of albuminuria other than nephritis, the author takes up the tests for albumen in the urine. Heat, nitric acid, picric acid, double iodide of mercury and potassium, sodium tungstate, and the brine test, are all dealt with in detail. Speaking of the double iodide of mercury and potassium test (Tauret's), he considers that it is the most delicate test for minute quantities of albumen. The possible sources of error with this test are the peptones, mucus, and presence of vegetable alkaloids in the urine. All these substances, with the exception of the mucus (which becomes filamentous), disappear on heating. The formula for the preparation of "Tauret's test" is as follows:

Potassii Iodidi,	-	-	3.22 grammes.
Hydrargyri Bichloridi,	-	-	1.35 "
Aq. Distil. (ad)	-	-	100 C.C.

In testing for albumen with this solution, it is important that the three following points should be attended to: 1, That the urine should be perfectly clear, being boiled, if necessary, with potash and filtered. 2, That it be acidulated (citric or acetic acid). 3, That a strong, clear light should be employed. It is preferable to pour the reagent into the bottom of the test tube, and allow the urine to trickle down upon it, drop by drop, along the side of the tube. When the quantity of albumen is small, as much urine should be added as will equal the amount of the reagent. The cloud formed is bluish-white. If the urine be heated, the cloudiness will be increased and flocculi formed.

After devoting a chapter to the consideration of the significance of urinary casts, the author proceeds to discuss the individual varieties of Bright's disease. Under this term he understands all forms of nephritis, and he considers that all forms of inflammatory processes in the kidneys may be comprised in the three varieties which he adopts—1, Croupous nephritis; 2, Interstitial

nephritis; 3, Suppurative nephritis. The two last are self-explanatory. By the term croupous, he means what is now commonly called the parenchymatous variety of Bright's disease. He is in accord with most recent observers in regarding interstitial and parenchymatous nephritis, not as essentially distinct diseases of the kidneys, but as identical in character, but differing in the degree in which the connective tissue and the epithelia are respectively effected. "They always coexist, and one cannot exist without the other being developed at least in some degree." The waxy and fatty kidney he considers simply an intercurrent or subsequent development upon one of the above forms, and not a condition independent of other lesions of the kidney.

We will not dwell on the manner in which the author deals with the nature, symptoms and causes of the different varieties, but will pass on to what we consider the best part of this, on the whole, very creditable treatise. We refer to the treatment.

In speaking of the symptomatic treatment of acute parenchymatous nephritis, the author claims for diuretics the most important place, and of diuretics he claims that digitalis and the convallaria majalis (lily of the valley) are the most trustworthy. Both of these agents act in a similar way as diuretics, viz., through their power of increasing the blood-pressure. Neither of these have any direct influence in increasing the quantity of urine. Speaking of agents that have a direct influence in lessening the quantity of albumen excreted in both acute and chronic nephritis, the author claims the highest place for the *tannate of sodium*. It is prescribed in doses of from 10 to 20 grains three or four times daily, well diluted in water. Reference is also made to the alleged properties possessed by gallic acid in diminishing the quantity of albumen. Allusion is made to the effects of nitroglycerine in diminishing increased arterial tension, no matter whether this is due to chronic kidney disease or arterial fibrosis, and with the diminution of the pressure there is marked relief. He considers, however, that the doses usually recommended ($\frac{1}{100}$ of a drop) are too large, producing great fullness and throbbing of the cerebral blood-vessels in many cases. Mention is made of an action supposed to be possessed by certain mercurial

preparations in acting more or less as direct curative agents in certain cases of chronic nephritis. Calomel is said to be the best agent in interstitial nephritis, while corrosive sublimate is recommended for the parenchymatous form of the disease. Both drugs are given in very small doses. No details of cases are given where a beneficial action has resulted from the use of the above mercurial preparations, and on this account the statements made by the author are of little or no value. The dietetic, hygienic, and general medicinal management of the interstitial nephritis is very fully given, and is well worth perusal.

We have said enough to indicate the general scope of this work. It certainly represents a considerable amount of labor.

The Pathology and Treatment of Gonorrhœa.—

By J. L. MILTON, Senior Surgeon to St. John's Hospital for Diseases of the Skin. Fifth edition. London: Henry Renshaw; New York: Wm. Wood & Co.; Montreal: Dawson Brothers.

This is a work of no less than 400 pages, entirely devoted to the subject of gonorrhœa. The best evidence that it is highly thought of by the profession is the fact that it has now reached the fifth edition. In speaking of Mr. Cheyne's so-called "abortive treatment" of gonorrhœa with iodoform and eucalyptus oil, the author says that it is a failure. This appears to be the experience almost universally of those who have put the method into practice; this, notwithstanding the fact that Cheyne reported that in his own practice he found the discharge becoming mucous in four or five days, and ceasing altogether in nine or ten days. Mr. James, who also used the iodoform and eucalyptus rods, reported that his patients got well within a week. In spite, however, of these favorable reports, it seems certain that Cheyne's iodoform rods have no influence in checking or in any way cutting short a gonorrhœa, and this treatment must take its place with the scores of others that have been highly recommended, but that have signally failed. There is at present no known agent that has the power of aborting a gonorrhœa. Speaking of copaiba, cubebs and sandalwood, given internally, the author

gives a long list of cases where one or more of these agents was the sole treatment employed, and where the result was certainly not any better than if the disease had been allowed to pursue its course without any treatment. There certainly is strong reason for believing that none of the agents mentioned have a direct influence in curing gonorrhœa. Those who claim virtues from them say it is owing to the fact that they are eliminated by the urine, and in this way influence directly the diseased structures. If this were so, the injections of these substances ought to be efficacious, but the contrary has been proved. Full details are given of the method of carrying out the local treatment of gonorrhœa, especially where the disease is confined to the anterior portion of the urethra. We, however, miss a description of Altmann's excellent apparatus for the irrigation of the posterior urethra. In many respects the work is, as might be expected, of an encyclopædic character. We, however, find no mention of a very important subject—the "tripperfäden" (gonorrhœal threads). While these threads are in the urine, a patient is not free from his gonorrhœa, and their disappearance is the best evidence that the disease is completely cured. Weeks after the discharge has stopped they can be found floating in the freshly passed urine. While they are present it is quite easy, by any excesses, to have a return of the acute urethritis, and many of the cases of gonorrhœa said to be cured by a few injections are undoubted instances of simply an acute attack grafted on a chronic one.

Mr. Milton gives a very complete account of the different complications of gonorrhœa—both local and general. His description of gonorrhœal rheumatism is particularly full and instructive. In this very distressing and troublesome affection he has found quinine answer best. He recommends it to be given in solution with sulphate of magnesia.

San-Remo Climatically and Medically considered.—

By ARTHUR HILL HASSALL, M.D., &c. New edition.
London: Longmans, Green & Co. 1883.

This neatly gotten-up and interesting book may be considered

as a new edition of Dr. Hassall's well-known work, "San Remo and the Western Riviera." San Remo is the last and most easterly of the world-renowned health-resorts situated in that district of the Alpes-Maritimes known as the Riviera di Ponente. The author claims for San Remo certain important advantages over the other resorts of that section. Thus he proves that the much-dreaded mistral, the curse of the Riviera, is not of such frequent occurrence there, and does not blow with such violence as in the case of many places situated more to the west. This town has a remarkably small rainfall also, ranking next to Malaga in that particular. However, while specially favored in some respects, San Remo has certain disadvantages. Thus, being in Italian territory, the traveller from the north is subjected to additional customs surveillance, and this often means delay and serious discomfort to the invalid. Then there is the greater difficulty experienced in obtaining suitable food, as all articles of English manufacture are exceedingly dear. Tea, sugar, bread and salt are very expensive. The manufacture of salt is a Government monopoly, and so sharply do the authorities look after this item in the tariff, that one is not allowed to take even a pailful of water from the sea, for bathing or other purposes, without a special permit. Hence persons of limited means can live much more economically in that portion of the Riviera under French rule than at San Remo, or any other place on the Italian side. The author discusses at considerable length the botany and zoology of the district about San Remo, and, with certain data arrived at from the study of these, attempts to prove much with respect to the climate and its curative properties. It is a mistake, however, to claim anything peculiar in this regard for San Remo, because of the similarity of the entire western Riviera. Dr. Hassall gives much valuable information for the guide of invalids visiting these parts, and concludes with an appendix describing fully the walks and various excursions that may be taken in the neighborhood of San Remo. We have read this book with very great pleasure and interest, and can confidently recommend it to any member of the profession seeking information of the kind contained therein.

A Treatise on Syphilis in New-born Children and Infants at the Breast.—By P. DIDAY, ex-Surgeon to the Hospital de l'Antiquaille, Lyons. Translated by G. WHITLEY, M.D. With Notes and an Appendix by F. R. STURGIS, M.D., Professor of Venereal Diseases in the New York Post-Graduate School, &c. New York: William Wood & Co.

The Library of Wm. Wood & Co. has received a valuable addition in the above publication. The subject of syphilis in young infants is one of universal interest both to physicians and to surgeons. Its intrinsic importance always claims our best attention with reference to both the actual subject of it and also those who may be accidentally brought in contact therewith. There is no class of cases in which the practitioner stands more in need of knowledge, skill and tact in their management. In private practice, a great many most delicate questions will arise in connection with proposed marriages, with suspicious conditions after marriage, and with possibilities of infectious states of newborn children. In dealing with these and many other problems which will at once suggest themselves, the prescience and the firmness of the medical man may be of the utmost importance. M. Diday is one of the recognised authorities on syphilis, and his extensive researches have been carried on during a long series of years. Many of the problems in infantile syphilis remain yet unsolved, and hence the undiminished interest attaching to its study. This book, together with that of M. Fournier on Syphilis and Marriage, form, together, probably the best presentation of the entire subject in accordance with modern scientific views which we have. The notes by Dr. Sturgis are very useful and appropriate, and the appendix by the same author contains a good deal of collateral matter which adds to the completeness of the work.

Veterinary Medicine and Surgery in Diseases and Injuries of the Horse.—Compiled from standard and modern authorities, and edited by F. O. KIRBY. Illustrated. New York: Wm. Wood & Co.

This volume forms the last of Woods' Library for 1883. It

presents briefly the various diseases and injuries of the horse, as commonly recognized, with their symptoms and appropriate management. It is not at all a scientific book, and does not seem anywhere to add to what is already found in most of the good works on farriery and veterinary lore. It is hardly of the character which we might have expected from its finding a place in this generally excellent series.

Practical Pathology: A Manual for Students and Practitioners.—By G. S. WOODHEAD, M.D., F.R.C.P.E., Demonstrator of Pathology in the University of Edinburgh, Pathologist to the Royal Hospital for Sick Children, &c. With 136 colored plates. Philadelphia: Henry C. Lea's Son & Co.

In a book of this kind the character of the illustrations is of unusual importance. A description of microscopical sections is almost useless. When, however, one is presented with a facsimile of the object as actually observed under the microscope, then the lessons conveyed by it are fully appreciated. The colored drawings in this work are admirably executed and form a striking feature. Almost every department of pathological histology is thus illustrated by actual original drawings. Complete directions are given for examining most successfully all sorts of diseased structures; and most carefully-written descriptions of the abnormal appearances are to be found in every chapter. It is certainly one of the most useful books for the modern student of pathology which we know of.

Elements of Practical Medicine.—By A. H. CARTER, M.D., Lond., M.R.C.P.L., Physician to the Queen's Hospital, Birmingham, &c. Second edition. London: H. H. Lewis.

This book, of very reasonable and handy dimensions, has been compiled chiefly with the view of "bringing the essentials of the subject within the grasp of those who are not disposed or have not the leisure to read the large and complete works" which form our standard text-books. This class of readers, the writer

thinks, is one "which usually meets with too little sympathy." It is well adapted for the purpose intended, and will no doubt prove to many a useful aid in acquiring the first elements of a sound knowledge of practical medicine.

Books and Pamphlets Received.

THE GENERAL PRACTITIONER'S GUIDE TO DISEASES AND INJURIES OF THE EYE AND EYELIDS. By Louis H. Tosswill, B.A., M.B., Cantab, &c. London: J. & A. Churchill.

ELEMENTARY PRINCIPLES OF ELECTRO-THERAPEUTICS FOR THE USE OF PHYSICIANS AND STUDENTS. Prepared by C. M. Haynes, M.D. Chicago: McIntosh Galvanic and Faradic Co.

CLINICAL LECTURES ON MENTAL DISEASES. By T. S. Clouston, M.D. With an abstract of the American Statutes by Charles F. Folsom, M.D. Philadelphia: Henry C. Lea's Son & Co.

DIAGNOSIS AND TREATMENT OF DISEASES OF THE HEART. By Constantin Paul. Translated from the French. New York: Wm. Wood & Co.

PRACTICAL MANUAL OF OBSTETRICS. By Dr. L. Kerrier. Fourth edition. Enlarged and Revised. With notes by Edward L. Partridge, M.D. New York: Wm. Wood & Co.

HOOPER'S VADE MECUM. Tenth edition; revised by Wm. Augustus Gray, M.B., and John Harley, M.D. Vol. I. New York: Wm. Wood & Co.

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

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 28th, 1884.

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

Fracture of the Femur.—The following is an abstract of a paper read by Dr. Jas. Bell on "Some Cases of Fracture of the Femur, treated by plaster-of-paris splint." Three cases were reported, all occurring in children.

The first, a little boy $1\frac{1}{2}$ years of age, with simple fracture in the middle third. The second, a boy four years of age, with fracture just below the trochanter from direct violence,—being run over by a heavily-laden cart.

The third case was that of a strong, healthy boy, aged 8 years, with fracture at the junction of the upper and middle thirds. In all these cases the treatment was the same. Ether was given,

the limb extended, and the fragments brought into position, and held there until a plaster splint had been applied, extending from the toes and including the pelvis and loins. Coaptation splints of pasteboard were moulded to the leg and applied between the layers of plaster bandage.

In none of these cases has there been the slightest trouble of any kind, and in each case when the plaster was removed the union was found to be most satisfactory. In the first case there was no appreciable shortening. In the second about a quarter of an inch, and in the third a little over a quarter, but less than half, an inch. These cases were exhibited, as also an old man aged 62 years who had a bad compound fracture of both tibia and fibula just above the ankle joint. The fracture of the tibia had been oblique and about three-quarters of an inch of the protruding fragment had to be removed with the saw before it could be reduced. The limb was then permanently fixed with plaster-of-paris, leaving the wound exposed through the small opening in the bandage. The wound was dressed with Listerian precautions and the patient was discharged at the end of eight weeks with a sound leg. He is now doing his regular work (six months after recovery), and has been for some time, without any inconvenience. The writer, in summing up, thought that in a great many cases the plaster-of-paris splint was the best that could be applied to a fractured femur, notably in children, in nervous and fidgeting people and in fractures complicated with delirium tremens, also among the poorer class of patients, where a suitable bed and good nursing (which are so essential in the ordinary treatment of extension) could not be secured. He also thought that the objections urged against it for fracture of the femur were very much overrated.

DR. GURD said that he would not like to risk treating an adult's fractured femur in this way, as he feared that before union had occurred there would be no pressure around the limb, owing to the rapid atrophy which follows disuse and bandaging, thus allowing displacement of the fractured ends.

DR. BLACKADER said he had broken the femur of an infant with the blunt hook in a difficult breech case and, assisted by

Dr. Sutherland, a gutta percha splint was applied, which answered admirably. Dr. Sutherland said he was going to use plaster-of-paris splints in these cases in the future.

DR. SHEPHERD quoted Heath as saying that there was no necessity to take in the joints where plaster-of-paris was employed.

DR. RODGER had lately used plaster-of-paris splint for fracture of the femur in a child aged 5 years with excellent results. He always uses this method of treatment for fractures of tibia and fibula.

Cases in Practice.—DR. BELL said that this evening he had been sent for by the Coroner to make a post-mortem examination on a young man, aged 28, who had been found dead in his bed. Death was found to have been caused by the bursting of a small aneurism into the pericardium. The aneurism arose from the lower and back part of the transverse portion of the arch. The young man had been treated as an out-door patient at the Hospital for pains in the back. Aneurism had not been detected.

Stated Meeting, April 11th, 1884.

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

DR. TRENHOLME exhibited *two pairs of Ovaries and Tubes* lately removed. One case was operated on 22nd March. Both ovaries were much diseased and enlarged to about four times their normal size. The patient was 32 years old, and had always suffered much at her monthly periods. Her sufferings have gradually increased year after year up to about November last, when she began to manifest symptoms of insanity of a melancholy religious character, with a suicidal tendency. Her monthly sufferings abated with the advent of the mental infirmity. The patient had been under the care of Dr. M. in Ontario, who suspected some disease of the internal organs of generation and sent her down to Dr. T. On examination both ovaries were found to be enlarged and tender, the uterus congested, and tender, but otherwise normal. The operation was made

with the hope of benefiting her mental condition. The wound healed by first intention throughout, and the sutures were removed on the 5th day, not a drop of pus being present. The patient made a rapid recovery, and returned to her home before the end of the third week. But little could be determined as to the result of operation upon her mind, but, so far as could be judged, she seemed somewhat benefited. The future of this patient will be watched with interest and reported to this society at another time.

Case 2.—Patient, aged 22, has suffered much for several years from pelvic pains, aggravated at each menstrual period. Both ovaries tender and enlarged, uterus congested and very tender and also retroverted. Attempts at replacement and the use of a pessary had been followed by pelvic cellulitis; even with greatest care could not tolerate a pessary. Rest and local treatment relieved for a time, but when she attempted to work was again laid up. As the girl had no friends or means of support, and her health precluded service I removed the specimens now before the Society. Both ovaries (as you see) are much enlarged, undergoing cystic changes. The tubes also very much congested. This patient has so far made a most unsatisfactory progress towards recovery. There seem to be no healing powers in her, and, while no dangerous symptoms threaten life, a tedious convalescence is looked for.

DR. HY. HOWARD considered the first to be a case of acute dementia, and said that peripheral irritation, especially from the organs of generation, will some times be followed by dementia in both sexes, often taking the form of religious dementia. Dr. H. mentioned two or three cases where young men on the first night of their marriage became insane.

Purpura Hæmorrhagica.—DR. KENNEDY mentioned that lately he had had under his care four cases of this disease, all in young children of different families. He asked if other members had seen an unusual number of those cases.

DR. REED said he had been treating one case at the Dispensary.

Nitroglycerine in Epilepsy.—DR. F. W. CAMPBELL spoke of the continual good results he is having with nitroglycerine in the treatment of epilepsy. None of the patients whom he has so treated have been entirely cured, but with all the attacks are milder and much less frequent. The usual dose which he gives is one drop of a one per cent. solution three times a day.

DR. TRENHOLME asked for the modus operandi of this treatment.

DR. CAMPBELL said that it was not easy to say how it acted; but if it is true, as some authorities affirm, that with epileptics there is anæmia of the brain from contraction of its arteries, then we can see how the nitroglycerine is useful, knowing, as we do, its action in dilating the blood-vessels of the head, as does smelling nitrite of amyl.

DR. HY. HOWARD congratulated Dr. Campbell on his success in this treatment of epilepsy and said that the Germans classified the forms of epilepsy as follows:—1st, Those due to contraction of the cerebral vessels from irritation to the vaso-motor nerves. Here bromide of potassium is very useful. 2nd, An abnormal condition of dura mater. Bromide useless. 3rd, Due to irritation of the anterior pillars of the spinal marrow. Ether spray best for this. 4th, Lesions of different parts of the brain or cord. Of course the difficulty is to be sure of the cause.

ONTARIO MEDICAL ASSOCIATION.

FOURTH ANNUAL MEETING.

This society met this year in Hamilton, in the City Hall, the Council Chamber being used for the meetings. The attendance of members throughout was very good, though not many were present from the eastern parts of the province.

The first session opened on Wednesday morning, June 4th, with a very good attendance—the President, Dr. Daniel Clarke, Toronto, in the chair. After the reading and confirming of the minutes, various communications were presented and read, amongst them a letter of regret from Dr. Fenwick, Montreal, at his inability to accept the invitation to be present as a guest

of the association. A communication was also read from the Women's Christian Temperance Union, which was referred for consideration to a special committee. Reports of some committees having been received, it was decided to postpone the reception of the President's address till the afternoon session and in the meanwhile proceed with the reading of papers.

The only paper read during the morning session was by Dr. Workman, on "*Aphasia*." This hale and hearty old member of the profession met with a very enthusiastic reception on his first appearance in the room, while his paper was listened to with much attention and interest. In beginning his paper he referred to the one read by him on the same subject last year, and complained that no discussion took place on it. After treating of the different theories on the subject of Aphasia, and the different varieties, he called attention to that variety which is often seen in lunatics where they are only capable of using interjectional remarks, on the cessation of which they relapse into mutism. He then proceeded as follows:—" Might we not charitably infer that something analogous to this direst condition exists in the brains of persons addicted to the senseless habit of profane swearing, who fill up with interjectional expletives those linguistic vacancies which their intellectual poverty renders them incapable of otherwise fitly tenanting? Imperatively and utterly to suppress the profane objurgations of these persons would be nothing short of reducing them to amnesic aphasia. Pass through the odoriferous knots of the great and the little unwashed, who ornament our street corners on Sunday evenings, or hearken, however reluctantly, to the silly twaddle of a string of our dandy promenaders, and then tell us how the poor creatures could contrive to escape profound mutism if deprived of their connecting linguistic links. One might as well expect to construct a wall of rough blocks without mortar. Men of good sense and cultivated minds do not swear because they have no room for oaths in their discourse. Be considerate then towards the poverty-stricken bipeds." This year a brisk discussion took place on the subject, and a vote of thanks was passed to Dr. Workman, with a request for publication.

The afternoon session was opened by the delivery of the President's address. The principal points touched on, after expressing his thanks for the honour conferred upon him, were, first, the improvements in educational matters during the last twenty-five years; then he took up the subject of specialties, pointing out the absurdities of dividing up the subjects of medical practice. After that he spoke at some length on the matter of advertisements in the press, both secular and religious, many of which by their insinuations, he considered, did so much harm; as also the advertisers who pretended to be so anxious for the welfare of their brethren. He also alluded to what he called the alphabetical advertisers and their advertisements, giving accounts of wonderful cases they cured. Finally the address spoke of the proper attitude of medical men towards the public and one another.

Dr. Howe, of Buffalo, delegate from the New York State Medical Association, was then introduced, and took a seat on the platform. The former presidents, all of whom were at the meeting, were also invited to seats on the platform.

The next paper read was by Dr. Tye of Chatham, "*On the Management of the Third Stage of Labor*," he being opposed to the employment of Dr. Credé's method entirely, but rather favoring a modification, and waiting, rather than express the placenta, so as to enable expulsion on the part of the uterus alone. Considerable discussion ensued, the general opinion apparently being opposed to too hasty expulsion, but some speakers thought Credé's method had been rather mis-stated.

Dr. Powell of Edgar then read a paper "*On Later Antiseptics in Private Practice*," showing, in illustration, a very handy arrangement for irrigation made by taking an ordinary beer bottle, punching out the bottom, while an indiarubber tube was attached to the cork, and the bottle slung up by the bottom. A more convenient one he considered, though, was made by substituting a long indiarubber tube for the ordinary delivery tube of a Davidson's syringe. While the tube placed in the injecting fluid was weighted or exhausting by means of the bulb in the centre, the whole apparatus was converted into a syphon,

and any vessel could be used for the irrigating fluid. He also exhibited specimens of various antiseptics now employed, such as peat, wood-wool, punk, iodoform and various kinds of prepared gauze, also decalcified bone drainage-tubes. He spoke strongly in favor of the use of bichloride of mercury solution applied locally.

Dr. Griffin of Brantford then gave the history of a case of *Tumor in the Abdomen* which caused obstruction of the bowels, great pain being experienced and local swelling found. On *post-mortem* examination, the cæcum was found to admit only a No. 4 catheter. The specimen was shown to the meeting.

Dr. Brouse of Brockville read a short paper giving an account of two cases of *Strangulated Hernia* operated upon by him, and also of a successful *ovariotomy*, in which, on opening the peritoneum, a quantity of syrupy fluid was found, but no opening in the cyst wall, which, however, was very thin. The operation was performed under strict antiseptic precautions, with the exception of the use of the spray.

In the evening session, the first paper was by Dr. Burnham, Toronto, "*On the use of Carbolic Acid in Purulent Affections of the Eye*," a remedy whose value was rather disputed by those taking part in the subsequent discussion.

Dr. Thorburn, Toronto, then gave an account of a case of *Injury to the Spine*. The patient, while bathing, dived into water that was too shallow, and was noticed floating on his face, and when rescued, his spine was found to be injured, there being complete loss of power of the lower extremities. The spine was extended, and the patient lived 24 days, during which he apparently enjoyed life to a great extent, as he eat, smoked, and felt quite free from anxiety, though occasionally suffering pain. On making a *post-mortem* examination, it was found that there had been a dislocation of the fourth cervical vertebra, which was fractured and the spinal cord compressed. The vertebrae were shown to the meeting, and also a sketch of the spinal column and cord. Considerable discussion followed, and several cases were mentioned, amongst others, one by Dr. Workman, who gave the history of a case that lived four weeks; Dr. Hunt of Clarks-

burgh, one that lived a year ; Dr. McCargow of Hamilton, who had had seven cases, one of which lived a year ; and Dr. Brown of Galt spoke of the case of a patient who, after recovering apparently from an injury to the spine, about a year afterwards showed signs of diabetes, and eventually died of it.

The next paper was one read by Dr. Adam Wright, Toronto, "*On the Prevention of Puerperal Fever,*" a very able and well written paper. One point which he considered of great importance was the state of the mind, many cases, in his opinion, being due to excitement on the part of the patient, instances being given where, on removing any cause which tended to excite the patient, recovery from the fever was very speedy, and with a view to calming the patient's mind, he was therefore opposed to the idea that a labor should be viewed in the light of a capital operation. Another point upon which he laid great stress was the use of injections, which he considered inadvisable as a matter of routine : also, the use of pessaries, as tending to diminish the lubricating secretions. He advised, therefore, that the patient should make water in the knee-elbow position, as by this method small clots were enabled to escape from the uterus and vagina.

On the conclusion of Dr. Wright's paper, J. J. Mason, Esq., Mayor of Hamilton, one of the invited guests of the Association, was introduced to the meeting, and delivered a short address of welcome, in which he expressed the hope that the visit of the Association might be profitable to the members, and that it might not be the last. He also remarked that he took more interest in the proceedings than might be expected, because he was the son of a physician—Dr. Mason of Brantford.

The discussion on Dr. Wright's paper was then proceeded with, and was generally participated in, there being a good deal said, though, that had little bearing on the subject of the paper, so the President called the members to order, and Dr. Wright having replied, the discussion closed.

The last paper was read by Dr. Turver, of Parkdale, on *Uterine Displacements*, which he illustrated by a pessary that he used in anteflexions and prolapses. The pessary was a

lever, with rubber pad or apron, as the inventor called it, over the front part, intended to receive the anterior part of the cervix and prevent erosion. Several cases which had been successfully treated by this instrument were related, and some questions put by different members were replied to, and the meeting then adjourned.

On Thursday morning communications were read from Mr. Boxer, of Montreal, and Dr. Playter, of Ottawa, and their consideration postponed.

Dr. Graham then read a paper giving an account of several cases of *Idiopathic Anæmia*. He ascribed the origin of the disease to the nervous system, and with regard to treatment, preferred arsenic in the form of Fowler's solution. In the succeeding discussion Dr. Cameron, Cayuga, expressed the opinion that the disease was analogous to scorbutus as so many cases were seen amongst farmers, and especially in winter, when vegetable diet was scanty. Dr. Sheard, Toronto, considered it an error to ascribe all obscure diseases to the nervous system, but thought there might be possibly an abnormal condition such as would produce the changes found in the blood corpuscles. Dr. Arnott, London, inquired as to the value of eucalyptus, as he had derived great satisfaction from the use of it.

Dr. Groves, of Fergus, read the next paper, which was on the *Operative Treatment of Purulent Effusions into the Chest*. The trocar which he used was shown, the principle being that the trocar drew back in the canula till an opening was exposed in a short neck to which an india-rubber tube was attached for the injection of fluids. Dr. Groves favoured making two openings in the chest wall, while others who spoke, favoured the syphon principle and used only one, Dr. Powell, of Edgar, showing how he retained the tube which he used, an Esmarch's bandage being employed. Dr. Hutchinson, of Brussels, followed with the history of a case of *Hodgkin's Disease* in a girl aged ten, the left cervical glands being especially affected. The patient was shown to the meeting.

Dr. Worthington, of Clinton, then read a paper on "*Cerebro-Spinal Meningitis*," giving an account of the epidemic of

1871-72, as seen in the county of Huron, near Clinton, the treatment he found most successful being by aconite and morphine. Drs. Harrison, of Selkirk, and McCargow, formerly of Caledonia, spoke of cases seen by them during the same epidemic, as did also Dr. Campbell, of Seaforth. The afternoon session was opened by the exhibition of patients, Dr. Alexander, of Grimsby, showing a man with great enlargement of the lower third of the right femur which was very hard while the knee was very weak and bent inwards on standing or walking, the condition of the knee dated from an injury two years ago followed by another a year later. Dr. Osborne, of St. George, showed a woman with a growth in the left inner canaliculus that had been at first pustular, but afterwards became more tubercular, its duration being about 7 years.

The following resolution was then moved by Dr. Powell, of Edgar, and seconded by Dr. Fulton, of Toronto, and carried, "That the President for next year be requested in appointing the chairmen of the temporary committees to select gentlemen with whom he has previously made arrangements for the opening of discussions on special subjects in their departments. Each discussion to be opened by the reading of a paper by the chairman, which paper shall take the place of the reports heretofore expected."

Dr. Rosebrugh, of Toronto, read a paper on "*Boracic Acid and Boro-glyceride*," in the Treatment of Purulent Inflammation of the Middle Ear. After speaking of the necessity of antiseptic treatment in these cases as a long recognized fact and the objections made to them, he spoke of Boracic acid and the objections to it. Then he described the preparation of Boro-glyceride and its method of use. At first he employs a 50 per cent. solution and then gradually diminishes the strength of the solution, great care being taken to thoroughly cleanse both the internal auditory canal and the middle ear before the boro-glyceride is applied. By the use of this remedy he claimed that the treatment was greatly shortened, only taking three or four weeks, where it formerly took as many months. At the close of the paper it was shown that boracic acid floats on the surface of water, thus distinguishing it from borax, which sinks at once.

Dr. Harrison, of Selkirk, then read a paper on "*Vaccination*," in which he very ably and in his usual witty style answered the charges of the anti-vaccinationists. During the discussion which followed, Dr. Bryce, Secretary of the Provincial Board of Health, spoke of the difficulties experienced in getting proper vaccine to supply the profession.

Dr. Riordan, Toronto, described a case in which there was a septum completely dividing the vagina into two compartments while the uterus was also double. Dr. Brown, of Galt, read an account of cases seen by him in Edinburgh and London, and Dr. W. H. B. Aikins read a paper on the local treatment of Spermatorrhoea. The various reports of committees were received and that on Medical Ethics referred to the next meeting to consider at an early stage.

The committee on the questions put by the Women's Christian Temperance Union reported that some had only a social bearing while the others were too important for the committee to consider, so were left to the next meeting of the society.

The report of the nominating committee was received and adopted, the following officers being elected: *President*—Dr. Worthington, Clinton. *1st Vice-President*—Dr. Tye, Chatham. *2nd Vice-President*—Dr. Richardson, Toronto. *3rd Vice-President*—Dr. Brouse, Brockville. *4th Vice-President*—Dr. Powell, Edgar. *General Secretary*—Dr. J. E. White, Toronto. *Treasurer*—Dr. J. E. Graham, Toronto. *Corresponding Secretaries*—Dr. Irwin, Kingston; Dr. Harris, Brantford; Dr. Waters, Coburg; Dr. Hutchinson, Brussels.

The next meeting to be at London. As no communications or papers had been presented on the subject of *Bacteria*, a special committee on Bacteriology was appointed. The question of a Provincial Medical and Surgical Museum was referred to a committee consisting of Drs. Clarke, Worthington and White to confer with the Ontario Medical Council and Government. The usual votes of thanks having been passed, the meeting adjourned at 6.45 p.m. Although no public entertainments were given, the Association not wishing anything of the kind, a large amount of private hospitality was dispensed, and all seemed well satisfied with the proceedings.

CANADA

Medical and Surgical Journal.

MONTREAL, JUNE, 1884.

CONTAGIOUS DISEASES AND TRAVELLING.

The isolation of a person the subject of a contagious malady, for the purpose of protecting a community from the contagion is clearly founded upon the plainest common sense. Real—strict—isolation it is often difficult to secure, but it should certainly always be the aim of sanitary authorities to prevent the exposure of those under their care to any contagion as far as this can be accomplished. It is plainly a grievous moral wrong for any person who knows himself to be afflicted with a contagious disease to travel by public conveyances, where a number of unsuspecting persons are liable to suffer from his proximity. It is also as plainly the duty of every medical man to point out to any one thus diseased the injury he would be inflicting upon his fellow-passengers. What therefore can be said of medical men who would knowingly aid and abet persons laboring under the most alarming contagious diseases we know of to procure passage by rail and in cars occupied by numbers of other persons? Surely their guilt is great. Such occurrences as we have alluded to are fortunately rare, but within a few weeks of each other glaring examples of the transportation of small-pox in the one case and diphtheria in the other have been brought to light in this country. The former happened in Ontario and the latter in this city. The facts of the Ontario case have recently been substantiated at the trial of the offending parties. It appears that Dr. Whitely, of Goderich, drove one Little, who was suffering from small-pox, in his buggy and set him down 150 yards from the station. Little was going, on the doctor's

advice, to London. At Clinton, his disease having become known, Little was locked into an empty baggage-car by himself and taken to the small-pox hospital at London where he was cared for. Great indignation was everywhere expressed and actions were taken against Little and Dr. Whitely; both were convicted of the misdemeanour and the former suffered a nominal imprisonment and the doctor was fined \$20, the judge remarking that he was lenient in consideration of the youth of the accused. The Montreal case was as follows: A woman, from the Eastern States, was on a visit to friends in a country district about 60 miles from this city, accompanied by three children. Two of these showed symptoms of diphtheria of a severe type. On the third day of the illness, the mother states, she was advised by the local practitioner to take them by rail to Montreal, receiving orders not to tell anybody what was the matter with them. This she did, and arriving here put up for the night at a hotel. The following day the sick children were taken into the Montreal General Hospital. At this time the worst case of the two was in a lamentable condition—glands greatly swollen, mouth open, abundant running from the nose, intense foetor of the breath, laryngeal symptoms already showing themselves, and he rapidly sank and died next day. The other child recovered. What action was taken in this case? None that we know of. The matter was made public through the papers and must have been reported to the sanitary authorities, but no pains were taken (as far as our information goes) either to sift the facts, to disinfect the premises occupied, to punish the guilty, or enforce a lesson upon the community. There is a degree of apathy hereabouts concerning contagious disease that is very remarkable. There is a good deal of talk about preventive measures, and so forth, but the inactivity displayed in this instance shows how easily foci of these communicable affections can be established here and how certain these are not to be stamped out in the beginning.

THE CONSTITUTIONAL TREATMENT OF TUBERCULOSIS OF JOINTS.

During the last four or five years there has been an evident change in professional opinion as to the part played by constitutional conditions in general, in causing and shaping many of the more common chronic diseases of joints. The prominent part taken by tuberculosis in originating disease of the articular structures of bone has, it may be said, only been recognized by surgeons within the last three years. Even yet there are a few who consider that injuries are the sole cause of such diseases as the ordinary chronic hip disease of childhood. Prominent among the supporters of this one-sided view is Sayre of New York. He goes so far as to maintain that hip joint disease is always of traumatic origin, and that constitutional conditions like tuberculosis have no part in the origination of the disease.

We remember that this view of Sayre was stoutly maintained by a prominent Canadian surgeon who read a paper on chronic joint disease at the meeting of the Canada Medical Association, held in Hamilton in 1878. In the discussion which followed the reading of this paper Dr. R. P. Howard eloquently and forcibly urged the necessity of taking a more comprehensive view of the causation of these cases. He showed how much *tuberculosis*, and how little *traumatism* had to do with cases of chronic joint disease.

The views on this subject urged by Dr. Howard seven years ago, are if we mistake not, the views almost universally adopted by the prominent surgeons of the day. It is particularly in Germany that the important part played by tuberculosis is now recognized by surgeons.

The tuberculous infiltration takes place, not in the soft structures of the joint as a rule, but in the articular extremity of the bone, the soft structures becoming secondarily affected. There is great similarity in the way in which tubercle affects the lungs and bones. In the case of the former the infiltration nearly always takes place into the lung texture, the pleura becoming only secondarily involved. In the case of the bone the cancel-

lous structure is not unlike the tissues of the lungs and the synovial membrane bears a somewhat similar relation to the cancellous structure as does the pleura to the lungs. Primary tuberculosis of the synovial membrane is as rare as primary tuberculosis of the pleura.

It is important when dealing with the management of chronic joint diseases, not only to know that tuberculosis is an important factor in their condition, but also it is important to know that the disease begins in the hard structures and not in the soft structures of the joint. It is not the intention here to refer to the local treatment of these cases, but to make mention of the importance of not neglecting general measures.

No doubt, when the tuberculous nature of many cases of hip joint diseases is recognized, excision will be more generally performed than it is, but on this subject and the equally interesting and important one of the so-called "anti-tuberculous properties" of iodoform we will not now enter. At present reference will only be made to the general treatment of joint tuberculosis by means of arsenic.

Langenbeck, a few weeks ago, gave an account before the Berlin Medical Society of six cases of tuberculosis of joints treated with arsenic after excision had been performed. Three of the cases were where the elbow joint was resected, one where the hip joint was resected, and in the two remaining cases the knee joint had been removed. All on account of tuberculosis. The details of only one case are published up to the present. It was that of a child aged 8, who was brought to Langenbeck last December, with inflammation of the left hip joint of a year and a half standing. The child was very much reduced and had almost constantly considerable elevation of temperature. The region over the left hip joint was greatly swollen, and so sensitive that the examination had to be made under chloroform. The joint was immediately excised. The head of the femur was in part destroyed and dislocated. The resection was made beneath the level of the trochanter. The acetabulum was so infiltrated that it had to be perforated, and a portion of it in all its depth removed. The granulations on

the remaining soft structures were carefully scraped away. The large cavity left was carefully irrigated with corrosive sublimate (1 to 1000). Two drainage tubes were inserted, the lips of the wound were brought together and covered with iodoform gauze, slight extension was put on the limb. For a few days the state of the patient was very favorable, the temperature became normal, and there was freedom from pain. After eight days, however, the temperature commenced to rise in the evenings, and the wound to pour out a large quantity of pus. The already almost healed wound was laid open, and the copious discharge of pus soon reduced the patient's strength so much that nothing but a fatal issue was looked forward to. The temperature varied from 100° in the mornings to 104° in the evenings. Quinine and other agents, including cod liver oil, had no effect in allaying any of the symptoms. Arsenic was now given, at first in doses of one drop and after a few days two drops of Fowler's solution. After fourteen days of the arsenical treatment the condition of the child changed wonderfully. The temperature fell to normal, and the appetite improved rapidly. The wound commenced to heal and in the course of four weeks it had become superficial. The general state of the child had quickly undergone a wonderful change from an apparently hopeless condition to one of considerable vigor. In Langenbeck's remaining five cases results similar, and almost as striking, as the one related, occurred.

The results obtained by Langenbeck are certainly very striking and demand the serious attention of all those who have to do with the treatment of such cases. It is idle speculating as to the way in which it can possibly act for good in these cases. It appears improbable that the good effects can be attributed to the marked hæmatinic properties which we know it does possess.

In a future number we intend making reference to the action of arsenic in lymphomatous tumors. There has quite recently been published evidence of this action of such a nature as to leave no room for doubt but that we have in arsenic an agent that is capable of curing many of these cases.

Medical Items.

—The ashes of Prof. S. D. Gross weighed about seven pounds. They were enclosed in a marble urn about three feet high, unornamented and without inscription, and placed beside the coffin of his late wife in the family vault at Woodland Cemetery.

MATERNAL FOUNTS.—There is living in Montijo a woman with four mammary glands; two are situated in their ordinary place, and the other two, a little smaller, perpendicularly and two centimetres above, one on each side, with their corresponding nipple. She is at present nursing a child with the four breasts, all having an abundance of milk. (*Il Siglo.*)

ANTISEPTIC ABSORBENT SPONGE.—Mr. Sampson Gamgee showed before the Medical Society of London, April 21st, an artificial antiseptic sponge of his invention. A small capsule, containing eucalyptus or other antiseptic, was enclosed in absorbent cotton; outside of this was a layer of cocoanut fibre, and outside of this more absorbent cotton-wool; the whole being enclosed in gauze. When about to be used the capsule could be broken by a blow of the fist, and the absorbent cotton became permeated with the antiseptic. He said these sponges could be made at a very trifling cost, and hoped they would come into use as a cheap substitute for ordinary sponges; they possessed this great advantage, that when required for use they were certain—however long they might have been kept—to be antiseptic: and, being so cheap, they might always be destroyed after being used.

VASELINE.—Amongst all the new preparations of petroleum, vaseline, the original form of petroleum jelly, still holds its own. Its perfectly stable qualities, its resistance to all putrefactive changes, renders it pre-eminently suitable for use as the basis of numerous ointments. Its soft and emollient nature at the same time indicates it as the most appropriate agent for all soothing applications requisite for tender surfaces, such as the nares, the eyes, &c. Much as the standard is used, it deserves, from its many good qualities, still more extensive employment.