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CANADA
MEDICAL & SURGICAL
JOURNAL.

A Monthly Record of

MEDICAL AND SURGICAL SCIENCE.

EDITED BY

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THE OLDEST MEDICAL JOURNAL IN CANADA.

BY RICHARD MACDONNELL, M.D., MONTREAL.

A few months ago there came into my hands a volume of the first medical journal published in this country. The readers of the CANADA MED. & SURG. JOURNAL may possibly find some extracts interesting as well as instructive.

In January, 1826, the *Quebec Medical Journal*, edited and published by Dr. Xavier Tessier, began its career. It appeared every three months, and was a remarkably well printed and well got up little journal, the articles being written, some in French, some in English. In the preface, the editor alludes to the great progress the profession in Canada has been making, and hopes that before long the doctor's apprentice (*l'élève du médecin*) will find in his own country the means of gaining the knowledge that will enable him to become a fit guardian of the health of his fellow-citizens.

The journal is undertaken with the view of benefiting the medical profession and of destroying those superstitious prejudices on the part of the public which tend to continually paralyze that zeal for scientific pursuits which should characterize the Canadian physician.

Each number of the *Quebec Medical Journal* is divided into three parts. 1, Reviews of standard medical works. 2, Record of recent advances and discoveries in the science of medicine. 3, Original articles and news items of local interest.

The first number of the *Journal* contains lengthy reviews of

some of the famous medical works of that day. Ward "*On Distortions of the Spine*," and Sir Astley Cooper's work "*On Fractures*" occupy the greater part of the number, the articles being selected from the *London Medical & Physical Journal* (the *Medical Times & Gazette* of the present day.)

The domestic department interests us most. An epidemic of measles visited Quebec in the autumn of 1823, and lasted until January. It was observed that in few cases was there a bright eruption, but that almost universally the skin was very pale, the sweating profuse, and that retrocession of the rash was of very frequent occurrence. Many children died of the disease.

The editor exhorts his *confrères* to struggle against the foolish popular prejudice in favor of over-heating the patients in measles and small-pox. The dislike of the French Canadians to vaccination is noted by the editor: "L'indifférence qui règne en ce pays pour la vaccine (Picotte de vache) est portée à un tel point, qu'il nous est arrivé plus d'une fois d'avoir été refusé d'inoculer des enfants parce que nous ne voulions pas inoculer la petite vérole." By an unfortunate fatality, he goes on to say the introduction of vaccine into Canada has been accompanied by difficulties originating in the carelessness and negligence of those in charge of public institutions in neglecting to interest the public in the beneficial results of vaccination.

The quarterly report of the Montreal General Hospital, from the 1st February to the 1st May, 1825, shows that there were 83 admissions in the quarter. On the 1st of May, 1825, there were 13 patients in the institution. During the whole three months there were but 146 consultations in the out-patient department. Drs. Caldwell and Robertson had attended during the quarter, and the latter had prepared the report. The following were the diseases treated:—Remittent fever, 2; continued fever, 7; inflammation of the eyes, 2; delirium tremens, 1; inflammation of the lungs, 9; inflammation of the peritoneum, 1; consumption, 1; inflammation of the liver, 2; rheumatism, 4; white swelling, 2; scald head, 3; measles, 1; erysipelas, 2; catarrh, 10; dysentery, 2; dyspepsia, 2; scrofula, 1; syphilis, 3; psoriasis, 2; cancer 1; scald, 2; whitlow, 2;

fracture, 4 ; fracture, compound, 1 ; distorted spine, 1 ; concussion, 1 ; deafness, 1 ; contusion, 1 ; sprain, 1 ; ulcers, 7 ; frostbitten, 1 ; itch, 3. Total, 83. The reports for the next two quarters were prepared by Drs. Stephenson and Holmes respectively.

Dr. Louis Talbot contributes to the April number a report on the diseases which have prevailed in Three Rivers and its environs from Aug. 25th, 1825, to March 26th, 1826. Here is a good description of typhoid fever occurring in the country. A violent storm occurred in August, which the author considers to have been the cause of an outbreak of fever in that district. "Une espèce de synochus ou fièvre continue, dont les principaux traits partageaient de la nature du typhus." Several in the same family were attacked at the same time, but the symptoms varied in each patient. Many died of it. In almost all the cases there were symptoms referable to the brain, the lungs or the intestines. Headache was present, but disappeared at the end of three or four days, leaving all the other febrile symptoms unabated. There was obstinate diarrhœa, which tended to recur after the use of astringent remedies. The endemic lasted until the winter time, and then made its appearance in certain villages on the south shore of the St. Lawrence. Dr. Talbot specially notes that the autumn seemed more a continuation of summer than the approach of winter. This storm caused much mischief, according to the good doctor's way of thinking, for he attributes two more epidemics to its malign influence—one of measles, another of whooping cough.

In the same number, Dr. C. N. Perreault of Quebec reports an interesting case of meningitis caused by the presence of a worm in the ear. "L'enfant de M. Paul Thibaudeau, Bourgeois de cette ville, âgé de deux ans et demi," suddenly complained of violent headache and pain in the right ear. This continued from September, 1825, to March, 1824, accompanied with fever and slight convulsions, contraction of pupils, and other symptoms of pressure at the base. The case was therefore regarded as one of acute hydrocephalus. After using many remedies, it was found that large doses of opium alone gave relief. Dr.

Perreault being at this crisis summoned, applied large emollient poultices to the right ear. Ten days afterwards the mother noticed something in the right ear. Dr. Perreault extracted "un ver long d'environ cinq ponce et demi et de grosseur proportionée, ressemblant parfaitement à ces vers blancs que les enfants rejettent souvent par l'estomac ou par les selles." Recovery followed.

Mr. John Gray, surgeon of St. Gervais, reports the extraction of a pin from the perinæum of a boy who for five years had been suffering from wandering pains in the abdomen, followed by a difficulty in voiding either urine or fæces.

Drs. Morin and Painchaud report success in the treatment of uterine hemorrhage by ergot of rye.

In the first quarter of 1826 Dr. Tessier reports the prevalence of typhus in Quebec, and recommends the plan of treatment of some practitioners—the use of cold water both externally and internally during the course of the fever.

An epidemic of influenza occurred in Lower Canada that winter. More than half the people were attacked. The treatment in vogue at this time consisted in rest in bed, steam inhalations, combined with the administration of James' powder and calomel.

An extract from the *Lancet* reports a case in which Mr. Mohr, a Berlin surgeon, extracted six worms from the ear of a child who had labored under the same train of symptoms noticed in Dr. Perreault's case. Two of them were said to have been deposited in dry earth, and to have, in two days, been transformed into chrysalides; in five days they became perfect insects, with spotted wings, belonging to the genus *tachina*.

The July number contains a list of subscribers to the *Journal*, and amongst them we find His Excellency the Governor-General, the Honorable the Chief Justice, Monseigneur le Coadjutor de Quebec, l'Hon. Orateur de la Chambre d'Assemblée, the Hon. the Collector of Customs, the Attorney-General, the Military Inspector of Hospitals; F. Blanchet, chirurgien, &c., M.P., Quebec; Hugh Caldwell, surgeon, &c., Quebec; E. W. Carter, surgeon, &c., Sorel; A. Cherrier, avocat, Montreal; Thomas

Fargues, M.D., Quebec; Anthony von Iffland, surgeon, Sorel; P. Laterriere, chirurgien, les Eboulements, and many others.

A very grand public dinner was given by the profession in Quebec to Dr. Pierre de Sales Laterriere, at Malhiot's Hotel, on the 31st August, 1826. The departure of Dr. Laterriere for England was the occasion of the banquet. Dr. F. Blanchet, who was in the chair, proposed the following toasts. The band of H.M. 71st Regiment supplied the appropriate music.

After the King and the Royal family had been duly honored, the health of His Excellency the Earl of Dalhousie was proposed and responded to with three times three right loyally.

The chairman, in proposing the health of the guest of the evening, observed that not above thirty years ago there had not been in Canada one medical man a native of the country. The present meeting was composed chiefly of Canadian practitioners, some of whom had already achieved a well merited celebrity in the profession. Not long ago he was the only Canadian practitioner in the whole country. He referred to Dr. Laterriere in most eulogistic terms, and spoke of the unremitting efforts he had made in aiding the advancement of the medical profession in his native land—(cheers)—the leading part he had always taken in the founding and improving of charitable institutions, and his disinterested loyalty in sacrificing his professional career, in order to take part in the defence of his country.

Dr. Laterriere, in responding, said that he was glad of the opportunity of publicly expressing his gratitude to his professional brethren for the valuable services they had rendered him during the long and painful illness from which he had just recovered. Turning to the subject of medical education in Canada, he bitterly deplored the entire absence of medical schools in the country. The search for knowledge in foreign lands entailed expense so great as to bar the entry into the profession of many who might have become its ornaments and contributed to its advancement.

The following toasts were then duly honored :—

“ To the memory of John Hunter and the medical institutions of Great Britain.”

National March.

“To the memory of Xavier Bichat and the medical institutions of France.” *French March.*

“To the memory of Benjamin Rush and the medical schools of the United States.” *Yankee Doodle.*

“To the Charitable Institutions of Canada.” *Canadian March.*

“To the Countess of Dalhousie and the Canadian Fair.” *Lady Mary Ramsay's Reel.*

“To Madame Pierre de Sales Laterriere and her family.” *Canadian Air.*

“The Board of Examiners,—May it continue to be composed of men who will always have at heart the respectability of the profession in the country.” *Canadian Country Dance.*

“The Hotel Dieu of Quebec, an asylum for the indigent sick. May it also become the asylum for medical science in Canada.” *Canadian Air.*

The guest of the evening then rose and proposed to drink to the success of the *Quebec Medical Journal*.

“The *Quebec Medical Journal*,—May the physicians and surgeons of this country and the public in general give to this work the degree of encouragement to which it is entitled.”

A la claire fontaine.

Several volunteer toasts were proposed, and songs were sung by Drs. Laterriere, Whitelaw, Tessier, &c.

Take it all in all, it was a very pleasant evening.

In January, 1827, Dr. A. F. Holmes and Dr. Arnoldi, of Montreal, published in the *London Medical & Physical Journal* a case of malformation of the œsophagus and trachea. This gave dire offence to the editor of the *Quebec Medical Journal*. He takes them to task for not publishing in their native journal. He is totally unaware whether this conduct has been intended as a sort of bravado offered to his journal, but on consideration, thinks them incapable of such a base motive.

In another editorial, Dr. Tessier truly states that 1826 will be a memorable year in the history of medicine in Canada. It is the date of the birth of the first medical journal and of the first medical society.

At a general meeting of the medical practitioners of Quebec,

held on the 30th November, 1826, Dr. Joseph Morin in the chair, it was resolved that a medical society be formed. Its constitution, which resembled that of modern institutions, was drawn up. Dr. Morin was selected President; Dr. C. N. Perreault, Vice-President; and Dr. Tessier, of the *Journal*, Secretary.

The *Quebec Journal* died of starvation in 1827. What became of the Quebec Medical Society?

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED 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.

Our Present Knowledge of the Relations between Micro-Organisms and Puerperal Fever.—This is the title of a timely paper by Dr. Lomer, assistant at Professor Schröder's clinic in Berlin, appearing in the July (1884) number of the *American Journal of Obstetrics*. As remarked by the author, "the recent discussion upon puerperal fever at the New York Academy of Medicine demonstrated very forcibly what various opinions are still held upon this subject, and especially as regards its contagious principles, by some of the leading members of the profession in America;" and he adds, "but ideas expressed a few years since in the memorable discussion of the New York Obstetrical Society show that in that country the subject is considered from still more widely divergent standpoints." Dr. Lomer disclaims any attempt at solving the various questions involved, but aims only at collecting and presenting facts regarding the relationship between micro-organisms and puerperal fever. The author first relates "Facts derived from Pathological Anatomy." In this part of the paper, the observations of Mayerhofer, Waldeyer, Orth, Wolff, Ehrlich, Heiberg, Klebs, Litten, Pasteur, Recklinghausen, Steurer and Fränkel are mentioned, and then the author describes in detail microscopical observations made during last winter on three cases of metria occurring at the University Polyclinic connected with the Woman's Hospital in

Berlin. The following is a *resumé* of the facts from pathological anatomy collected by the author :

“ I. The chain-like micrococci have frequently been found both in the exudations and in the organs of patients having died of puerperal fever.

II. All observers have noticed the same characteristic variety.

III. Different species of them have hitherto never been described.

IV. It seems as though all who sought for them have been able to find them in every case.

V. More recent researches have shown that, besides this chain-like micrococcus, other micro-organisms—*i.e.*, bacteria—can be found in puerperal fever.”

Facts derived from the cultivation of micrococci :—Coze and Feltz, in 1869, attempted to cultivate the blood from puerperal patients in sugar-water. Their results were negative. Orth found that the chain-like micrococci could be kept quite a length of time without change of character, and without the appearance of resultant bacteria. Pasteur's experiments show the possibility of cultivating germs from patients suffering with puerperal fever, and show that not only can these germs be found in such patients, but that when puerperal fever, as such, does not exist, they cannot be found. These observations are of great interest and importance. It was the chain-like micrococci that Pasteur found as a result of these cultivations. Experiments in this direction have been recently made, and are still continued, by Prof. Schröder's request, at the Imperial Health Bureau, under the supervision of Dr. Struck, the director of the institution.

The author next relates facts derived from experiments upon animals. Then the known facts with reference to the relations of scarlet fever, diphtheria, erysipelas and pyæmia, to puerperal fever are given. Our space will not permit of my giving in greater detail the many interesting and important facts (including a number of experiments by Dr. Jovanovic, of the Imperial Health Bureau, on material furnished by Prof. Schröder's clinic.) I append Dr. Lomer's summary of conclusions :

1. Of all micro-organisms found in puerperal-fever, the chain-

like micrococci seem to be those to which we should especially direct our attention, and to which we should attach the greatest importance.

2. When in any case of puerperal fever their presence has been detected in the exudations, they have also been found in the deeper organs.

3. They have been found in erysipelas, scarlet fever, diphtheria, and puerperal fever, and in each possess the same form, and show the same disposition towards fertilizing fluids and coloring matters.

4. Although it is very probable that different varieties do exist among these diseases, we, as yet, have no positive proof of the fact.

5. A differentiation, according to size, is an extremely difficult, perhaps hopeless task, but, according to manner of growth, it may be possible.

5. Vaccination with cultivations of these micrococci from different diseases has proved fatal to animals, but has given no typical or characteristic results.

7. Chain-like micrococci have also been found in infected wounds, and in the blood of pyæmic patients.

8. The pathologico-anatomical investigations thus show that these clinically related diseases (puerperal fever, erysipelas, diphtheria, scarlet fever, and pyæmia) possess similar micro-organisms.

9. Besides the chain-like form, other micro-organisms may be present in puerperal fever—*i.e.*, mixed infection.

10. The presence of these latter in the cadaver does not always prove that they existed in the living body; on the contrary, they are often the result of post-mortem decomposition.

11. It is probable that the processes of decomposition are sometimes present before death actually takes place; different varieties of micro-organisms therefore found, for instance, during the death-struggle, may have nothing to do with the cause of the disease.

12. It is, as yet, impossible to classify puerperal fever, as regards course and prognosis, according to the varieties of micro-

organisms found (Doleris), or according to their mode of invasion (Frænkel).

13. In some cases no micro-organisms have been found, but this does not prove that they did not exist.

The Action of Salicylate of Sodium upon the Uterus.—The conclusions of Dr. Balette (*These de Paris*) are that salicylate of sodium, in the ordinary therapeutic dose, calms the pains of dysmenorrhœa, appears to promote menstruation, and causes its reappearance in amenorrhœa. In four cases of pregnant women, in whom the medicine was given in large doses, abortion occurred in two; but no such result was observed in other cases of pregnancy in which the remedy was administered in moderate quantity.—(*Phila. Med. News*).

Phantom Tumors.—It is a well-known fact that in certain women, especially those of hysterical tendency, and most frequently after some illness that necessitates long confinement to bed and invalid habits, or after some mental shock, a general enlargement of the abdomen, simulating a tumour, occurs. This enlargement disappears completely in the condition of anæsthesia, to recur when the latter condition passes off. The condition has been called "phantom tumour." A satisfactory explanation of the cause of these tumours and their disappearance under anæsthetics has not yet been given. Local contraction of the abdominal muscles may produce a partial swelling, but not the general enlargement characteristic of the condition in question. Neither is Ebstein's explanation to be regarded as entirely satisfactory. According to this writer, it is due to a paralysis of the pyloric sphincter, which permits of the passage of the air gulped down to the stomach in large quantities passing without hindrance to the intestines, and so causing a general distension of the abdomen. To accept such an explanation, one must admit that, in the condition of anæsthesia, simultaneously with the subsidence of the abdominal enlargement, large quantities of air are suddenly evacuated, and that, towards the end of the anæsthesia, air is again swallowed in large quantities. To say the least, this is exceedingly improbable.

Krukenberg, in an article based on a carefully reported typi-

cal case published in the *Archiv f. Gyn.*, Bd. XXIII, Hft. 1, advances a new and, as it seems to me, much more rational explanation than any hitherto proposed. In this he is assisted by observations of Duchenne and H. Meyer on the form of the lumbar portion of the spinal column, and of Schatz on intra-abdominal pressure. The patient, a virgin of 24, had menstruated regularly since her 18th year. The periods lasted two days, and were very painful. In the spring of 1883, the menses ceased altogether. Since January, 1880, till her admission (Dec. 15, 1883) to the clinic, she had suffered from hysterical convulsions—at first infrequent, but almost daily during the last two years. During the same period she had suffered from vomiting, which, of late, had occurred after almost every meal. On 28th Feb., 1880, two days after a menstrual period, she was seized with symptoms of pelvic inflammation. Although apparently not severe, the patient kept her bed in consequence for 14 months continuously. From April, 1881, till December, 1882, she was out of bed for a few hours daily. Up to this date she had been taking morphia daily. During and after the inflammation there had been enlargement of the abdomen. Since she began to leave her bed, but especially since she had been able to be up all day long, a constantly increasing enlargement of the belly had existed. She was taken to the Clinic on account of the spasms, vomiting and suspected ovarian tumor. She was badly nourished and anæmic. In the walking, standing, and lying positions there was equally great protrusion of the abdominal walls. This was most marked in the lower part. Nowhere was there either dullness on percussion or circumscribed hardness. The tense abdominal walls did not permit of satisfactory examination, so anæsthesia was induced. The patient was placed in bed in the horizontal position. As soon as the anæsthesia was complete, the swelling of the belly completely disappeared, and through the now perfectly lax abdominal walls the vertebræ and pelvis could be clearly felt. The virginal genitals were normal. Remains of the previous pelvic peritonitis could be felt in the form of a thickening between the uterus and left ovary. As soon as the patient had recovered from the anæsthesia, the en-

largement of the abdomen returned. Subsequently the patient was examined more carefully in the standing position. The enlargement of the abdomen existed as before. The thoracic part of the spinal column was arched back, while, on the other hand, the lumbar portion displayed marked lordosis; the pelvic inclination very slight; the posterior surface of the sacrum nearly perpendicular; the lower extremities extended, but the ankle joint flexed. These conditions are induced, as is well known, to maintain an equilibrium when the abdomen is distended by any abnormal contents. In the absence of any such, the supposition was justifiable that the deformity could not be the result of the great distension of the abdomen, but that both were the result of a common cause, or that the first was the cause of the last. In fact the condition of the spine just described is produced when we aim at producing distension of the abdomen, and in conditions other than those of abnormal contents in the abdomen; especially in the condition of muscular weakness of convalescents. Duchenne found this deformity of the spine in paralysis of the erector spine in a case of progressive muscular atrophy, and also in a case of paralysis of the abdominal muscles from the same disease. Krukenberg believes that in the case just detailed there can be no doubt that the deformity of the spine was the result of weakness of the spinal muscles produced by long confinement to bed. There was no evidence of partial paralysis of spinal or abdominal muscles, as in Duchenne's cases. Now Schatz (*Arch. f. Gyn.*, Bd. IV., s. 193) has shown that when this condition of the spine exists, an increase of intra-abdominal pressure is produced. The increase thus produced is equal to the difference between a column of water 28 cm. and one of 50 cm. in height. To this increase of pressure the atrophic abdominal muscles must yield, and so the enlargement of the abdomen is produced. In the case under consideration, there was the remarkable circumstance that the lumbar lordosis persisted in the lying position. The diminished abdominal space in the lying position compensated for the similarly diminished intra-abdominal pressure, and so the abdominal protrusion persisted; but in anæsthenia, the abdomen became flaccid and—

proof of the correctness of the explanation—the lordosis completely disappeared. On the passing away of the anæsthesia the previous conditions returned. Another experiment without anæsthesia proved the correctness of the theory. With the patient lying on her back, the knees were grasped, and so the lower part of the spine raised from the bed. The lordosis being thus obliterated, the phantom tumor disappeared. The patient could then with effort lie for some time without lordosis, but the position was painful, and after a few minutes the previous position was resumed. A fortnight later, after repeated attempts of the kind described, the patient could lie for the greater part of the day with flaccid abdomen, and finally this became the permanent condition. It was much more difficult, as may be easily understood, for the patient to stand without lordosis, but with the help of a laced supporting corset or bandage about the pelvis, this was also overcome. The hysterical spasms and vomiting soon ceased.

Why the lordosis persisted in the lying position of the patient is not very clear. As the author says, it may, at all events, be considered certain that it was not due to any acquired accommodative change of form of the passive structures—the bones and ligaments—else anæsthesia could have had no influence on the conditions. It was much more probably the muscles of the spine that were concerned. It is well known that a muscle whose points of attachment are approximated gradually becomes shortened. This must have been the condition of the spinal muscle. Perhaps the hysteria had something to do with it. But this shortening must not be regarded in the light of an unyielding contracture; else the effect of anæsthesia upon the muscles must have been *nil*, which was not the case.

The author's explanation of the mode of causation of the tumour in this case and its disappearance under a næsthesia is, it will be observed, based on simple mechanical relations. Whether or not the earlier observed cases of phantom-tumour were produced in this way cannot now be decided, but it is highly probable that such was the case, when the whole abdomen was enlarged. In Spencer Wells' photographic illustrations of his

case, the important point of persistence of lordosis in the lying position cannot be determined, as the patient is in a half-sitting position, and the clothing is so arranged as to conceal the loins.

Notes of Two Hundred and Thirty-one Cases of Operation for Laceration of the Cervix Uteri.—This was the title of Dr. Thaddeus A. Reamy's (Cincinnati) address as chairman of the section of Obstetrics at the meeting of the American Medical Association held at Washington in May last. The author's first operation was done in February, 1874. No fatal result in the whole list. In six cases the operation was followed by perimetritis, parametritis or peritonitis. All finally recovered perfectly. Of the 231 cases, in 170 the laceration was bilateral, in 38 unilateral. Of these unilateral, 23 were on the left side and 15 on the right. Sixteen cases were stellate. In five cases there were lacerations of the posterior lip only; in two, of the anterior lip only. In 80 cases the laceration was extensive. In 15 of these it extended to the cervico-vaginal junction on both sides. In three cases the rent extended to the internal os. In one of these the vaginal wall was also extensively lacerated: the peritoneal cavity had probably been opened, followed by protracted cellulitis. This patient was a helpless invalid between the date of the injury and the operation. On one side it required 12 sutures to close the cervical and vaginal rent. Perfect success followed the operation; the patient was restored to robust health within six months. In 167 cases there was perineal laceration to an extent that left deformity. In 26 cases he operated on perineum and cervix at the same sitting. He does not hesitate to curette the uterus at the same sitting as the operation on the cervix, if it be deemed necessary, and thinks it lessens the danger of inflammation following the use of the curette. He believes strongly in the efficacy of free bleeding from the denuded surface as a means for promoting the involution of the uterus. To this latter end thorough denudation and the cutting out of all cicatricial tissue are important. As regards the kind of labor in the cases of laceration, it could not be determined with certainty except in a few cases. In 40 cases, the forceps had been used; two were craniotomy cases

and two version. He believes that early rupture of the membranes and attempts at forcible dilatation of the cervix by the fingers of the accoucheur or midwife, and the improper use of ergot, are far more fruitful sources of laceration of the cervix than the forceps. In Cincinnati 70 per cent. of labor cases are attended by midwives, mostly ignorant and unskilful. He admits, however, that the accident may occur in the hands of the most eminent and careful accoucheur. The importance of shielding the accoucheur from unjust censure by the patient or her friends is justly dwelt upon. The gynæcologist should voluntarily declare the unavoidable occurrence of these injuries in the great majority of cases. Dr. Reamy firmly believes in the strong predisposition to cancer in an unhealed laceration, and, in common with many eminent gynæcologists, he finds in this fact a strong argument in favor of trachelorrhaphy. In over 300 cases of cancer of the cervix of which he has notes, only one occurred in a virgin, and only 10 in married women in whose cases he could obtain no evidences of abortion or child-bearing. In only two of his cases did the author fail in getting union. In one of these he used catgut, and in the other the sutures were not drawn tight enough. In both cases perfect success followed subsequent operation.

The points in the author's mode of operation which are worthy of note seem to be the following:—He draws the uterus down as little as possible, especially if cellulitis have existed. He uses a nearly half circle needle with a very sharp point, and Chinese silk as the material for sutures. He prefers silk to wire, because it can be more accurately adjusted and may be left in from 15 to 30 days without cutting out. He washes out the cervical canal with a recurrent flow syringe at the close of the operation to remove any blood that may have found its way there during closure of the sutures. He directs the nurse to wash out the vagina with warm carbolized water within an hour after the operation. The vagina is not again syringed till the sixth day, and then daily till the patient is dismissed.—*Philadelphia Medical Times*.

The Question as to the Importance of Flexions and Displacements of the Uterus.—This is the title of a paper by Dr. Graily

Hewitt, of Londou, appearing in the *Lancet* for June 7th, 14th and 21st, 1884. The paper is apparently called forth by recent papers of Drs. Vedeler of Christiana, and Herman of London. The opinions of these two gentlemen, as a result of their observation, are, in general terms, that flexions of the uterus are much more common than is generally supposed, and that they often exist in the absence of symptoms that can be traced to the uterus as their source.

Dr. Graily Hewitt, as is well known, has been a life-long and consistent advocate of the doctrine that the deformities (flexions) and displacements of the uterus are a fruitful source of female symptoms. Without entering the arena of discussion on this much debated question, my own experience leads me to subscribe to most of the author's statements, and especially to that in which he formulates the non-recognition by many physicians, of the uterine origin of certain common symptoms, such as headache, nausea and vomiting, hysteria, leucorrhœa, dyspareunia, not to speak of marked pain or discomfort in the pelvic or lumbar region. The author embodies the result of his experience and observation in the following propositions:—1. "The uterus best performs its functions when its shape closely approximates to what has been termed the normal shape, and when it occupies its normal position in the pelvis. 2. Alterations to any material degree in the shape of the uterus are liable to give rise to complaints on the part of the patient, and not unfrequently occasion severe symptoms. 3. These alterations in shape, coupled as they frequently are with considerable variations in the position of the uterus, are very frequently associated with altered conditions of the tissues of the cervix or body of the uterus. When so accompanied with tissue changes they rarely fail to occasion marked symptoms. 4. It is found that the symptoms or complaints of patients presenting these associated conditions, (flexion plus tissue-change) are markedly relieved by adopting such procedures as are calculated to diminish the degree of the flexion, and thus to restore the uterus more or less completely to its normal shape and position. Further, it is found that the tissue-alterations are favorably influenced to a marked degree by restoration of the uterus to its proper shape."

The author concludes his paper in the following words:—"I would remark that there appears to me to be two principal reasons why the importance of uterine flexions as factors in uterine disease is doubted by some and disbelieved by others: 1. That the complaints made by women are too often treated as fanciful, whereas what is really wanting is a discriminative analysis of such complaints. 2. A want of recognition of the influence of defective nutrition in producing such alterations in the tissues of the uterus as predispose to, or constitute the first stages of, serious and troublesome disease of this organ."

Five Cases of Extra-Uterine Pregnancy operated upon at the Time of Rupture, by Lawson Tait, Esq., F.R.C.S.—Mr. Tait has seen some five or six-and-twenty cases of rupture of extra-uterine pregnancy, and, having been encouraged by his success in the surgery of other abdominal diseases, resolved to try what surgery could do in these cases.

For this treatment, of course, the main difficulty is in the diagnosis. but this is a small matter to Mr. Tait, who has now completely adopted the principle of always opening the abdominal cavity when he finds a patient in danger with abdominal symptoms. The diagnosis is not, perhaps, so difficult after all. In many cases the existence of pregnancy has been suspected before the rupture occurred. In the majority of these cases there is a misleading feature; the patient has never been pregnant, or has not been so for years, so that arrest of menstruation does not attract particular attention. If, however, it be found that the patient has been eight weeks or more without a period, that there is a pelvic mass on one side of the uterus and fixing it, and if sudden and severe symptoms of pelvic trouble and hemorrhage come on, the rupture of a tubal pregnancy may be suspected, and if an operation is to be done,—and it clearly ought to be done—it must be done without delay. So says Mr. Tait, and adds: "Early interference is clearly a chief element of success in modern abdominal surgery." He appends the report of five cases thus treated—abdominal section, ligature of the tube and its removal, and then careful toilette of the peritoneum—before closing." Of the five, four recovered.—*British Medical Journal*, June 28, 1884.

Correspondence.

LETTER FROM LEIPZIG.

(From a Special Correspondent.)

Leipzig is justly regarded as one of the great medical centres of Europe, and in the German Empire rivals Berlin in the renown of her medical professors and in the number of students which throng the lecture halls. With the great development of Berlin in the past twenty-five years, its medical school has assumed proportions and importance which place it somewhat in advance of that of the Saxon capital. The philosophical, legal and theological faculties of the Universities attract large numbers of foreigners, among whom are at present several Canadians.

As a city, Leipzig is large enough to offer excellent clinical advantages; and St. Jacob's Hospital, with its "barracks," as the pavillions are called, contains abundant "material" in all departments. The general university buildings are in the middle of the city, and are plain and unpretentious. The medical and scientific departments are in the outskirts, and occupy a long street well named *Liebig*. Beginning at the central end, one passes in the following order the large isolated buildings devoted to the various subjects:—Anatomical, Physiological, Physical, Chemical, Zoological and Agricultural Institutes, the Eye Hospital, the Deaf and Dumb Institute, the St. Jacob's Hospital, the Pathological Institute, the Veterinary School, the Botanical School, and, most distant of all, the Insane Asylum. The Institutes are usually three-story buildings, the lower flat devoted to teaching purposes, while the upper affords excellent accommodation for the professor and often one or two members of his staff.

The Pathological Institute is conducted very much on the model of Virchow's, and is in charge of Professor Cohnheim, with whom are associated Professor Weigert and Privat-Docent Huber. As, I dare say, most of your readers have heard, Prof. Cohnheim is seriously ill, and there is, unfortunately, no prospect of his recovery, as he has chronic Bright's disease (gouty). The loss will be most serious. As an experimental pathologist, he has no rival in Europe, and his lectures on General Pathology,

a second edition of which was issued last year, show a grasp of the principles of disease not inferior to his great master, Virchow, and a clearness of exposition quite as great. It is a pity the work has not been translated. The charge of the laboratory is virtually with Professor Weigert, to whom medicine is under a deep debt of obligation for the introduction of the use of aniline dyes in histological work, as well as for the unravelling of many knots in pathological histology. He is a model of industry,—first at work in the morning, last to leave at night,—extremely affable and attentive, qualities which go so far to make one's stay in a laboratory comfortable and agreeable. I know of no place where a man can better work at pathological histology. Dr. Huber, who does a large part of the instruction, is a most painstaking and skillful teacher. The number of autopsies is not so great as at the Berlin Institute, but one can see at least two or three a day.

The medical clinic is in charge of Professor Wagner, who for many years held the chair of Pathology, and succeeded Prof. Wunderlich in the chair of Clinical Medicine in 1877. He is well known to us as the author of the valuable work on General Pathology (Wm. Wood & Co.), and for many years edited the *Archiv der Heilkunde*. As a teacher of clinical medicine he stands in the very front rank. His method and manner remind one of Traube, which, in my opinion, is one of the highest compliments to pay a teacher. From 9.45 to 11 a.m. instruction is given upon cases brought into the theatre, usually three or four each day. At the beginning of the lecture, new cases are given out to the students, who go to the wards and make out the history, &c., and then, when one of their cases is brought before the class, the student whose case it is goes into the arena and states the prominent features, and makes the diagnosis. The physical examination is made by the student, and then a general summary is given to the class, with the necessary explanatory remarks. We all know how apt this method is—in some hands—to be dry and wearisome; details are obtained slowly by the student, and I have seen a class thoroughly tired, the professor irritated, and half an hour consumed in getting primary facts.

Prof. Wagner seems to get the details quickly, and the students appeared to me to be very much brighter than those at Berlin. To students coming to Germany for post-graduate study, I would most strongly recommend them to take a semester at this clinic. For the general practice which nine-tenths of doctors ultimately engage in, it is worth any dozen special courses that I know of. Among many interesting cases which I saw at this clinic, I will mention one—a very rare form of hysterical breathing. On June 30th, a girl, aged 15, was brought into the clinic, and long before the attendants had wheeled the bed into the theatre we could hear extraordinary cries succeeding each other with great regularity, and resembling somewhat the baying of an animal. When the bed was brought in, upon it was a slightly built, emaciated girl, sitting upright, and breathing in a noisy and remarkable manner, most distressing to witness and to hear. There was first a loud crying inspiration, preceded by three or four jerking attempts, also noisy, and then came a deep-toned expiration, the sound evidently produced by the vibrations of the soft palate. There appeared to be urgent dyspnoea, and the countenance of the child was expressive of the deepest misery. These respirations followed each other with great regularity, and had persisted since the night of the 22nd of May, when she woke up and began this form of breathing, which had never since ceased except during sleep. She had been hard worked at school, and had had mental excitement in preparation for her first communion. There was no disease of heart or lungs, and examination of the throat showed only the vibrations of the palate. Professor Wagner placed his fingers in the mouth and pressed down the jaw, and at the same time commanded her firmly to try and breathe quietly, which she did in a few minutes, and took water and told her name. In remarking on the case, he said that it could not be brought into the category of any known form of dyspnoea, and was probably an unusual manifestation of hysteria. From the loss of sleep and inability to take food the child had become greatly emaciated.

Perhaps the most notable figure in medical Leipzig is Prof. Ludwig, Director of the Physiological Institute, and the Nestor

of German physiologists. Indeed he has a higher claim than this, for when the history of experimental physiology shall be written, his name will stand pre-eminent with those of Magendie and Claude Bernard. He is now an old man, with bodily vigor somewhat abated, but, mentally, fresh and suggestive as ever. He has the honor of having trained a larger number of physiologists than any other living teacher; his pupils are scattered the world over, and there is scarcely a worker of note in Europe—bar France—who has not spent some time in his laboratory. Two circumstances have combined to this result—his extremely attractive and sympathetic nature, which has made of each pupil, not only a co-worker, but a life-long friend, and then his extremely suggestive mind, always ready to broach problems for experimental solution, and always able to assist in devising the methods and apparatus necessary for the carrying out of any given research. The laboratory is extremely well equipped, with histological and chemical departments, as well as the special physiological, which occupies the main portion. There are eight or ten men working at different subjects, some of extreme complexity. Thus, Dr. Lombard of Boston is endeavoring to work out the problem of the co-ordination of muscle, and to get the order of contraction, etc., has devised a most complicated piece of apparatus, by means of which he can take simultaneous tracings of the contraction of each muscle in the frog's leg. I was struck with one remark which Professor Ludwig made in speaking of English physiology, viz., the unfortunate influence which it had had in practical medicine and surgery, arising from the fact that its exponents and representatives had, in so many instances, drifted off into these branches, and he instanced Todd, Bowman, Beale and Lister. The association between physiology and practical medicine is much less close in Germany, where it is studied as a separate science in these large institutes, which offer for special students exceptional facilities, but the rank and file are not, I believe, so well instructed in their physiological work as with us in England.

It is very hard to adjust the two great functions of a University, or a part of it, as represented, say, by such an Institute.

The work which shall advance the science, which brings renown to the professor and to the University, is the most attractive, and in German laboratories occupies the chief time of the director. This function is specially exercised, and the consequence is that medical literature teems with articles issued from the various laboratories. On the other hand, the teaching function of an Institute is apt to be neglected in the more seductive pursuit of the "bauble reputation."

I was greatly interested in the work of Professor Leuckart's laboratory, and regret that I had not time to see more of it. He is Director of the Zoological Institute, and is known everywhere as the great authority on parasites. Fortunately, he was lecturing on them this semester, and I had the privilege of hearing part of the course. He has the largest helminthological collection in the world, and has specimens sent from all countries for determination. A large number of men are at work in his laboratory, chiefly at comparative anatomy, and I was pleased with the thoroughness which Prof. Leuckart exacted in every bit of work undertaken. My impression is, that for an extremely good biological training, one could not be under a better master.

There is not a fully organized Veterinary School here, but only a department in connection with the Agricultural College, and a professorship of the science, which is held by Dr. Zurn, the well-known joint author, with Kuchenmeister, of an important work on parasites. The arrangement is very similar to that of the Ontario Agricultural College, and in the various State Colleges, where lectures on diseases of animals, etc., are given to the students. Prof. Zurn is, unfortunately, in ill health, but there is considerable activity in his laboratory under his assistant, Dr. Plant. Dr. Zurn is one of the leading authorities on the diseases of birds, on which subject he has just issued a valuable text-book.

I was extremely pleased to make the acquaintance of Prof. Winter, the University Librarian, and for 40 years or more the editor of Schmidt's *Jahrbüch.* Like most editors—medical—of my acquaintance, he has a kindly and a genial nature, and I am indebted to him for many acts of politeness.

Hospital Reports.

MEDICAL AND SURGICAL CASES OCCURRING IN THE PRACTICE OF THE
MONTREAL GENERAL HOSPITAL.

MEDICAL CASES UNDER THE CARE OF DR. ROSS.

*Case of Tubercular Peritonitis—Apparently sudden onset—
Pleuritic Effusions—Thoracentesis—Death and Autopsy.*

G. C., æt. 17, an under-sized, emaciated, colored lad, admitted January 23rd, 1884, suffering from an attack of acute peritonitis, which had begun suddenly three days before. Previous history revealed nothing beyond some irregularity of the bowels and occasional slight pains in abdomen for about a year, during which time he had been losing some flesh. On admission, prominent features of the case were pain, with deep and superficial tenderness, and tympanites in abdomen, most marked in hypogastrium. Bowels constipated. Temperature 104° ; pulse 92, full and soft. A soft, blowing systolic murmur at apex; transmitted to left. Lungs normal. Under simple treatment, pain and tenderness became much less, but tympanites persisted to end of case. Temperature fell and remained sub-febrile until February 1st, after which it was very irregular, rising to 102° , 103° , or 104° at night, and usually falling to normal or subnormal in the morning.

Feb. 11th.—No pain. Has superficial, but no deep, tenderness about umbilicus. From this time bowels remained regular.

Feb. 28th.—Return of pain and tenderness in abdomen. A triangular dull area over front of chest, from left border of sternum, below level of third rib; apex about right nipple.

March 18th.—Morning temperature does not descend below 100° . Has dry cough. On examination, pleuritic friction in left axilla. Abdomen distended and hard. *22nd.*—Friction extended to left base. *30th.*—A loud friction heard over præcordia, loudest about left nipple; thought to be pericardial.

April 12th.—Pericardial friction gone. Pleuritic friction heard over anterior border of left lung. Still a loud friction at left base. Has occasional night sweats. *17th.*—Effusion into left pleura; friction sound still heard behind. Heart displaced to right of sternum. Loud blowing murmur heard in both inter-

scapular regions. Continued distension of abdomen. No ascites. 27th.—Effusion greatly increased ; dullness of entire left chest ; distress of respiration. 30th.—Aspirated and ̄xxx of serum removed from left pleura ; great relief to breathing.

May 7th.—Fluid reaccumulated ; aspirated and ̄xvii of serum removed ; breathing again greatly relieved. 19th.—Fluid reaccumulated, but caused no dyspnoea. Return of pain and tenderness in abdomen during last few days. Died to-day of exhaustion.

Autopsy.—In abdomen, extensive peritonitis ; abdominal organs and coils of intestines completely glued together. Peritoneum studded with innumerable whitish nodules, the size of small marbles ; to the naked eye strongly resembling secondary carcinoma ; on section, firm and caseous. These nodules, on examination by Dr. Wilkins under the microscope, proved to be of the nature of caseating tubercle. *Thorax*—forty ozs. fluid in left pleural sac. Parietal pleuræ thickened ; on left side, presents numerous small nodules similar to those in peritoneum. On right side, also, a few are seen. Left lung collapsed, completely airless, lies close against vertebral column ; a few small cretaceous bodies, apparently old miliary tubercles, just under visceral pleura ; none in lung substance. Right lung normal. *Pericardium*—Parietal layer firmly adherent to pleura over left lung, from which a few small nodules project out of it as round elevations. Lining membrane smooth ; shows no signs of inflammation. *Heart*—Mitral segments a little opaque ; aortic valves present a few small warty vegetations. Abdominal organs normal. Brain normal.

Remarks.—When this case first came under observation, it presented all the characteristic and typical features of an attack of acute peritonitis. Recognizing the necessity of searching for the exciting cause, this was specially investigated, but without any result. His clinical history, as far as could be learnt, threw no light upon this attack. No symptoms pointed towards any pre-existing disease of the abdominal organs, and, as far as he knew, he had been in his usual health, and had not been losing weight markedly up to the time of the sudden onset of the pain. It was

therefore necessary to await further developments before coming to a decision on this point. The acute attack appeared to subside entirely under appropriate treatment, leaving behind it only vague, uneasy feelings in the abdomen and a slight degree of tenderness. The patient was actually then, for a time, looked upon as a convalescent. This promising condition, however, was of short duration. Abdominal pains recurred in different regions of the abdomen, new seats of tenderness developed themselves, a remittent type of fever was set up, and gradual emaciation was observed. As this state of things showed itself, we began to realize that the patient was the subject of some grave constitutional affection, and the suspicion of tubercle was fully entertained. We sought repeatedly for evidence of that condition in the lungs, which, if present, would have been strongly corroborative. The physical signs there, however, were uniformly negative. Later on, extensive acute pleurisy occurred, for a long time dry, but ultimately accompanied by considerable serous effusion, for which thoracentesis was twice performed. Long before this occurred, the diagnosis of tubercular peritonitis had been definitely made. It was founded upon the persistence of localized peritoneal inflammations, with marked constitutional derangement and deterioration. In the majority of cases, with such facts before us, the choice lies between tubercle and carcinoma, and, of course, the usual considerations of age and so forth must be applied in any given case to enable the distinction to be made. The absence of ascites is a noticeable feature.

Case of Pernicious Anæmia at advanced age—Improvement under Arsenic—Relapse—Small blood-counting—Death from Asthenia—Autopsy.

W. H., æt. 65, saddler, admitted May 23rd, suffering from dyspnoea on exertion, cough, loss of appetite, and general weakness. Up to about two years ago, had always been healthy; never had ague, rheumatism, or syphilis. In his younger days was a heavy drinker; latterly, moderate. About two years ago he began to feel weak, and to find that his wind was not so good as it used to be; his friends also noticed that he was losing

color and becoming very pale. He entered the Hospital in February, 1883, suffering from dyspnoea on exertion, being quite comfortable when quiet in bed. On any severe exertion he suffered from palpitation and cardiac pain, and occasional fits of dizziness. At this time, and for a month previous, he had also swelling of the feet and ankles during the day, always disappearing at night. Had lost but little flesh. Was markedly anæmic; appetite poor. A soft, blowing basic, systolic murmur was present; no venous hum. Apex beat increased in intensity just under nipple. Blood very pale and watery; red blood-corpuscles to cubic centimetre, 1,150,000; white to red, 1-115. Examined by Dr. Osler and reported thus: "Marked deficiency of red blood-corpuscles, slight relative increase of white; some microcytes, but not very many; not many granular masses of Schultze; a good many large-sized red corpuscles; marked irregularity in the size of the red cells, which is almost enough in itself to diagnose pernicious anæmia; no nucleated red cells seen." *Lungs*—Few crackling râles at both bases. *Liver*—Five inches vertical dullness. *Spleen*—No enlargement. *Eyes*—Few small extravasations in the retina of each eye. He left Hospital in March, general condition much the same; was readmitted Nov. 7th of same year, suffering from same symptoms as before. Had been able to able to work pretty well all the summer till a couple of weeks before admission, when he thought he caught cold. Condition much the same as when in hospital before; a little emaciated. *Blood on admission*—Characters much the same as before; red blood-corpuscles to cubic centimetre, 1,530,000; white to red, 1-300. Improved under Fowler's solution of arsenic. Left hospital in January of this year. Blood thin, better color, and less watery; red blood-corpuscles to cubic centimetre, 2,570,000.

Readmitted May 23rd, suffering as before from dyspnoea on exertion, cardiac pain, palpitation, noises in ears, occasional fits of dizziness, cough, loss of appetite, and general weakness. Since leaving in January last, says he has been able to work at his trade pretty well; breath and appetite fairly good up to about a month ago, when he caught a severe cold, and has been very

ill ever since ; occasional swelling of feet and ankles ; two prolonged attacks of epistaxis the week before admission (no more nose-bleeding up to time of death) ; appetite poor ; tongue very pale and flabby ; bowels constipated. At this time he was somewhat emaciated ; muscles very soft and flabby ; skin has a peculiar sallow, dirty, lemon-yellow tint ; conjunctiva a little yellowish ; mucosæ pale, almost colorless ; is very weak, and can with great difficulty walk across the ward ; is fairly comfortable in bed. Temperature 98° ; pulse 96, regular, but very soft and feeble ; respirations 28. On listening to heart, a harsh blowing systolic murmur is heard, with maximum intensity over sternum, opposite third rib, transmitted up the sternum into vessels of the neck, and also with diminished intensity to the apex, not propagated to left of apex. Moist râles at bases of both lungs. Liver dullness slightly increased. No splenic enlargement. Urine clear, acid ; specific gravity 1012 ; no albumen nor sugar. Blood examined : Very pale, thin and watery ; white corpuscles are relatively a little increased ; red blood corpuscles vary greatly in size and shape, and are very pale, an average of seven countings gives 800,000 to the centimetre ; great many small red cells or microcytes ; no enucleated red blood corpuscles ; no granular masses of Schultze ; white to red as 1-100. Eyes examined by Dr. Buller, and retinal extravasations found in both as before. He rapidly grew weaker, becoming very drowsy and languid, being very delirious and rather noisy the last two nights, wandering somewhat in the day also. He became weaker and weaker, till he died at 8.30 Thursday evening, the 28th. Since admission, the pulse never rose above 100, nor the temperature above 100° .

Autopsy.—Body that of an old man, medium size, fairly nourished. Rigor mortis well marked. Extreme pallor of skin and subcutaneous tissue. *Abdomen*—Omentum, stomach and intestines very pale. *Liver*—Left lobe somewhat enlarged ; surface much puckered ; small cicatrix on upper surface of right lobe ; pale on section ; presents numerous dark red spots, like minute ecchymoses. *Spleen* apparently normal ; good color ; not pale nor enlarged. *Kidneys*—Left extremely pale ; cap-

sule rather adherent; organ cuts firmly; cortex rather diminished in thickness. Great contrast to right kidney, which, except being firm on section, is of a good color and apparently normal. Neither liver nor kidneys give reaction with iodine. *Thorax*—*Heart*: Over an ounce of fluid in pericardium; large "milky patch" from attrition over right ventricle; on opening heart, a quantity of thin, watery-looking blood escapes from right auricle and ventricle, left empty; no coagulated blood; right heart dilated; left ventricle dilated and hypertrophied; aortic valves competent, but roughened from patches of atheroma, as also is the aorta down to the iliacs; tricuspid orifice considerably dilated; other valves normal. *Lungs*—Left normal; right, pleura adherent throughout, and much thickened; at apex of right lung is a mass of hard, cretaceous matter, the size of a walnut. *Brain*—Pale and a little œdematous. *Retinæ*—Small hemorrhages at periphery. *Bone marrow* is red, like fœtal marrow. Abundance of leucocytes and red corpuscles; no nucleated red cells found.

Remarks.—The advanced age of this patient (65) is to be noted, as it is beyond that when malignant anæmia is to be looked for. The actual enumeration of the red corpuscles by Gowers' Hæmacytometer is remarkable, the cubic centimeter containing once only 1,150,000, and later on, the smallest number I have ever seen, viz., 800,000. Arsenic, in fair doses, lessened the subjective symptoms, and actually increased considerably the proportion of red cells. The improvement, however, was only temporary, relapse soon taking place. This corresponds with what I have seen in other cases of the same kind. The cardiac murmur heard during life was confidently predicted to be of organic origin, and not simply anæmic. The roughened aortic valves and atheromatous aorta proved this to be the case. The only means relied upon for distinction were harshness and propagation to an unusual extent for blood murmurs.

Case of Acute Pneumonia—Hæmoptysis—Early defervescence—Rapid Recovery.

J. W., æt. 30, single, 'longshoreman, came to hospital June

18th, 1884, complaining of pain in left side, with cough and hæmoptysis. Family history indefinite ; no history suggestive of tuberculosis. *Previous history*—Always healthy till 10 years ago, when he had typhoid fever, during the convalescence from which he developed a cough, short and dry, and which, though never very troublesome, has never left him. He says he has never been so strong or fleshy since as before the fever. Has had several attacks of rheumatism during past ten years ; laid up in bed each time. Last November was in the General Hospital for injury to left side of chest, the result of a fall ; had a little hæmoptysis immediately after the fall, with sharp pain in side ; the hospital report says : “ No fractured ribs, is a delicate-looking man, gives a phthisical history, but no physical signs.” Left hospital cured in three days, and worked steadily up to March last, being all the winter quite as well as before the accident. Had a severe attack of rheumatism in March ; in bed three weeks. After this attack, went to work and felt fairly well up to three weeks ago, when, from exposure to cold and wet, he had a severe chill, followed by dry cough, with pain in left side, aggravated by breathing or coughing. This cough much worse towards morning ; came on in paroxysms, obliging him to sit up in bed, and frequently set up vomiting. No hæmoptysis whatever since injury. Has felt flushed and feverish in the evenings, preceded by chilly sensations, with severe sweats at night for the past three weeks ; never had these sweats before. Appetite has been failing rapidly during this time, also rapid emaciation. Present attack began on the 15th June, three days before admission, patient having worked up to Saturday night, the 14th. Felt as well as usual Sunday morning (15th). Commenced with a burning heat in the head, dizziness, and sense of great weakness ; slept none that night, the symptoms continuing unabated ; the cough also now becoming very troublesome. Next morning, walked down stairs, felt very dizzy, and during a fit of coughing expectorated about a pint of dark frothy blood ; no vomiting. Had a little hæmoptysis yesterday morning. The pain in side and cough much worse last two days, with but very little expectoration.

On admission.—Patient is a medium-sized, dark-complexioned man, very much emaciated ; bony parts of joints, ribs, clavicles, etc., very prominent. Muscles flabby ; skin warm and moist ; no incurvation of nails or clubbing of fingers ; feels, as he says himself, very weak. Voice is very weak, low and hoarse ; can with difficulty speak above a whisper : this trouble came on yesterday ; throat does not feel sore. Cough very distressing, paroxysmal, very scanty, and very viscid ; muco-purulent expectoration streaked with blood, some sputa being rusty. A little frontal headache. Appetite poor. Tongue moist, with slight brown fur. Some vomiting after fit of coughing. Bowels a little constipated. Temperature 102° ; pulse 96, soft and weak ; respirations 42, ratio $1:2\frac{1}{2}$.

Physical signs.—Chest very long and narrow ; clavicles very prominent, hollow above and below both ; expansion very deficient on both sides, more marked on left. Base of left lung very dull on percussion up to angle of scapula ; also lower half of axillary region. Over the dull area the breathing is harsh and blowing, with a few sub-crepitant râles. Mild bronchophony in same area. Lungs otherwise normal ; apices clear. Heart : marked pulmonary accentuation ; otherwise normal. Urine high-colored, sp. gr. 1022 ; slight deposit of urates ; no albumen or sugar ; chlorides present.

Patient was put on Liq. Ammon. Acet. ζ ii ; Ammon. Mur. grs. v 4 q.h. ; ζ iv whiskey per diem, with mustard, &c., to the side. The day after admission, being the fifth day of the acute trouble, the temperature and respirations fell, and patient was very much better. All his symptoms continued to improve very rapidly, his voice becoming strong, cough gradually disappearing, and his appetite returning, the physical signs above-mentioned rapidly disappearing, till, on the 27th June, ten days after admission, he left the hospital perfectly cured, and with the base of his left lung quite clear, breathing only slightly feeble, and unaccompanied by any adventitious sounds. Temperature 97° ; pulse 64, strong and full ; respirations 22.

Remarks.—This case presented, as a feature of considerable interest, a copious hæmoptysis amongst the initial symptoms of

an acute lobar pneumonia. This is of very rare occurrence—so rare that its presence is very apt to embarrass the diagnosis at that stage. It is hardly mentioned by the standard writers. This is the second case I have met with where subsequent observation of the patient left no room for doubt as to the absence of any other possible causative lesion. This patient's previous history was specially suggestive of phthisis, but in spite of this, the diagnosis—an acute lobar pneumonia, non-phthisical—was fully sustained by subsequent events. Complete defervescence occurred on the evening of the fifth day, decidedly earlier than is customary.

Case of Acute Pleurisy—Effusion—Remittent Fever—Prolonged Illness—Recovery.

E. S., æt. 26, farmer, admitted 23rd May, 1884, complained of pain in the right chest, with shortness of breath and cough. Patient had a sister who died of some acute pulmonary trouble (phthisis?); family history otherwise good. Up to six weeks ago he was perfectly healthy. At this time he was attacked with a severe, sharp, shooting pain in his right mammary and axillary regions; much aggravated by a full breath or by coughing. At the same time he began to cough, but had no expectoration. This acute pain lasted for one week, and since that time till admission he has suffered from some pain in the side; dry, hacking cough, shortness of breath on exertion, with great loss of flesh and strength.

On admission he is found to be a very tall (6ft. 2in.), large-framed man, considerably emaciated, pale and anæmic, unfit for any exertion on account of shortness of breath, and troubled with a short, dry cough. *Physical Signs in Chest*—Chest somewhat long and narrow, but well-formed; the intercostal spaces of right side are noticed to be somewhat obliterated, and expansion is markedly deficient on this side. Heart apex seen and felt in 5th space (left) 1 inch outside the nipple line. *Measurement*—Right side, 18in.; expansion, $\frac{3}{8}$ in. Left side, 17 $\frac{1}{2}$ in.: expansion, 1 $\frac{1}{2}$ in. On right side whole front is very dull below the 3rd rib; the lower part of this area flat, lateral

regions dull ; lower half flat. Behind, very dull below angle of scapula, base flat : clear note over left lung and both apices. Respirations are feeble, but vesicular over the dull areas ; almost absent at the base of right lung. Though weak, the breathing is clear and vesicular in right apex. No râles heard anywhere. *Voice*—Fremitus diminished over dull area, absent at base. Resonance diminished and feeble at base ; in places, modified bronchophony, almost egophony. Heart sounds normal. Ordered Potass. Iodid. grs. x ; Tr. Calumb. ʒss, t.i.d., with Iodine lotions to side.

Up to 23rd June, one month after admission, the temperature was very remittent, with evening elevations to from 100° to $103\frac{1}{2}^{\circ}$, and morning remissions to from $98\frac{1}{2}^{\circ}$ to 96° . Since that date his temperature never rose above $99\frac{1}{2}^{\circ}$, and he has rapidly gained in weight and strength.

June 5th.—Expectoration (scanty and glairy) was examined for lung tissue and tubercle bacillus with negative results. Physical examination at this time shows gradually diminishing dullness, breath sounds louder, but some moist râles on inspiration, prolonged and somewhat blowing respiration over dull area. A loud-rubbing friction is heard in lower part of right infraclavicular region and upper part of right axilla. Left lung : Clear note, breathing nowhere strong and vesicular ; no râles. Ordered Emp. Canth. 4×4 in right infra-clavicular region.

June 15th.—Loud friction still heard behind, below 6th rib, in right axilla and in right infra-clavicular region. Breathing stronger, still somewhat tubular about right mammary region. No moist râles anywhere.

June 23rd.—General condition about the same ; occasional night sweats. Lungs : percussion about the same, but better note in 3rd space in front ; breathing stronger, still somewhat blowing behind ; no râles ; loud friction still heard in right axilla.

July 16th.—Discharged. Temperature normal since 23rd June ; rapid improvement, with gain in flesh and strength ; weighed 176 lbs. on June 28th, 182 lbs. on July 10th. Friction still heard in right chest ; percussion somewhat clearer, but

still dull at base of lung; breathing somewhat harsh in right infra-clavicular region; no râles anywhere. Taking Ol. Morrhuæ ʒij. t.i.d.

Remarks—The case of E. S. was instructive, inasmuch as the symptoms were well calculated to mislead. E. S. was referred to me by a medical friend in the country, from whom I had some facts of his patient's history. These had been such as to lead to a strong suspicion of the existence of tuberculosis. The persistence of the cough and the deterioration of the general health lent the chief support to this view. From a careful enquiry into the facts as given above in elucidation of the physical signs as then detailed, I could not share this view. The diagnosis was acute pleurisy with plastic and perhaps moderate serous effusion and an absence of tubercular deposits. In accordance with this view a very hopeful prognosis was given. After a short time, however, our patient failed markedly, he emaciated and became affected with a very decidedly remittent character of fever during several weeks; he also sweated at night. Repeated physical examination, however, failed to show any evidence of pulmonary deposits. At this time the sputa were examined for the bacilli of tubercle; none were found. If this means of diagnosis is to be of real practical service, such doubtful cases as this must furnish the opportunities. So far it negatively supported the original opinion. The progress of the report shows how, shortly after, loud, dry frictions occurred, the temperature fell to normal and the patient returned to his home convalescent, physical signs of thickened pleura alone remaining.

Reviews and Notices of Books.

Hooper's Physician's Vade Mecum: a Manual of the Principles and Practice of Physic, with an outline of General Pathology, Therapeutics, and Hygiene. Tenth edition. Revised by WILLIAM AUGUSTUS GUY, M.B., Cantab, F.R.S., F.R.C.P., Consulting Physician to King's College Hospital, &c., and JOHN HARLEY, M.D., Lond., F.L.S., F.R.C.P., Physician to St. Thomas' Hospital, &c. Vol. I. New York: Wm. Wood & Co.

An old friend in a new guise. The original text is maintained throughout, but numerous important additions have been made, so that it shall include many subjects not developed at the time of the first edition (1823). It appears to have been for a long time the only work of the kind extant, and even yet there is ample scope for its usefulness, spite of the numerous handbooks of practical medicine recently introduced to the profession. "In making extensive changes and additions to this edition, the original intentions of the authors, to make this work practically useful to the student and practitioner, have been strictly adhered to, and we believe it will now be found the most comprehensive work of the kind heretofore published in this country." That is the statement made in the revisers' preface, and we fully concur therein.

Practical Manual of Obstetrics.—By DR. E. VERRIER, Lecturer on Obstetrics in the Faculty of Medicine of Paris. Fourth edition, enlarged and revised. One hundred and five illustrations. First American edition, by EDWARD L. PARTRIDGE, M.D., Professor of Obstetrics in the New York Post-graduate Medical School. New York: W. Wood & Co.

This work by a French author has been added to the standard library. It is no doubt useful to every medical practitioner to have a knowledge of the practice of the several branches of our Art in other countries besides his own. No doubt we have set forth there the teachings which have, through experience, commended themselves to the French accoucheurs, and which are

therefore to be received with all due respect. In many particulars, however, these will be found to differ considerably from the rules enunciated by the most recent English and American authorities. It is not therefore to be supposed that we should specially recommend Dr. Verrier's book as a guide or text-book, though a comparison of the points of variance between it and our own manuals will afford instruction and ample room for thought. Thus, in removal of the placenta, the old plan of making traction on the cord is recommended, the expression, "treatment of Credé," being condemned. The latter is said to be only admissible "when the cord has ruptured, or is very delicate and friable, or, again, when we suspect an abnormal insertion." Now, there is, certainly, difference of opinion on this subject, but we think the great majority of accoucheurs are inclined to favor the Credé method over the old expectant plan or traction upon the cord. In Chap. VII, numerous directions are given as to the care of the parturient woman. Amongst other things, great stress is laid upon the necessity for quietude and avoidance of excitement—*e.g.*, "the mother should know nothing about the baptism, if this ceremony occurs a few days following labor." "The bed is to be made the third day following delivery, and then is not to be touched until after the fever." Attention is also to be directed to suitable clothing, and she must not go out too soon. "Science records numerous examples of puerperal fever contracted from neglect of these precautions." Now, we cannot think such teaching calculated to do much good. What is meant by "after the fever," in the above quotation, is very indefinite, and, with reference to puerperal fever and its causation, the modern view of its dependence upon a true and specific living poison is one of the most important deductions from bacteriology. If this be true, how can it result from such causes as those mentioned. Exposure to a draught of air, catching cold in some way, are often made scapegoats and shouldered with the responsibility of producing puerperal fever, but it is a dangerous doctrine to teach. Though we have felt bound to point out the existence of such-like peculiarities in this manual, we have not failed to admire the admirably terse manner of its composi-

tion, the completeness with which the entire subject is handled in small space, and make no doubt that it gives a fair representation of the practice of the French schools. It will no doubt be much appreciated by the subscribers of the Library and the general medical public.

Hand-book for the Dominion of Canada, prepared for the Meeting of the British Association for the Advancement of Science at Montreal, 1884.
By S. E. DAWSON, one of the Local Secretaries of the Association. Montreal: Dawson Bros.

We have been favored with a copy of this excellent guide to this country and hand-book of valuable information to visitors. It contains sketches of each of the provinces and their leading cities, all written in that pleasant style for which the author is so well-known. We advise all our Montreal friends to draw the attention of strangers to the existence of this excellent manual, which has been prepared for their express benefit. Even Canadians will be surprised, in its perusal, to find how many things they may themselves learn about their own country. It is accompanied by excellent maps of the entire Dominion, showing all the railway and steamboat routes.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, May 9th, 1884.

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

The following pathological specimens were exhibited:—

Aneurism of the descending Aorta—Erosion of Vertebrae—Pressure on Left Bronchus—Carnified Left Lung. DR. GEO. ROSS exhibited the specimen and narrated the case.

The specimen consisted of a large aneurismal sac occupying the descending portion of the thoracic aorta. The posterior wall of the pouch had been absorbed, and laid bare the bodies of several dorsal vertebrae, which were also considerably eroded. The left bronchus had been compressed, and the corresponding

lung was airless and carnified. The aortic segments presented a sclerosed and contracted appearance, and were inefficient. The lining membrane of the aortic arch extensively atheromatous.

The history of the case began with an attack of acute left-sided pleurisy more than two years ago, for which he had been attended by Dr. Ross. Physical examination at that time showed only the usual signs of pleuritic inflammation, and of incompetency of aortic valves, with consecutive changes in the left side of the heart. Aneurism was not suspected. A year later he consulted Dr. Blackader, who referred him to Dr. Ross once more, he believing that further organic disease existed. After recovering from his pleurisy, the patient had continued to suffer from persistent pain in the left side of the chest, and shortness of breath had become aggravated. Physical signs were: dullness over whole left lung, and respiratory sounds distant and feeble over same area. Double basic cardiac murmur. Tracheal traction evident. Aortic aneurism diagnosticated. Subsequently there were developed well-marked neuralgia of 5th, 6th and 7th intercostal nerves, which could be traced out by exquisite superficial tenderness; also a remarkably strong, heaving pulsation at the xyphoid and neighboring parts, apparently lifting the heart itself against the chest. The addition of these signs allowed the aneurism to be placed with certainty in the descending part of the aorta. He died with symptoms of bronchitis and increasing asphyxia.

Cast from Membranous Dysmenorrhœa.—DR. GURD exhibited what he thought might be a cast from a case of membranous dysmenorrhœa. The specimen was quite fresh, having been ejected from the vagina that morning. The patient, æt. 25, has been married two years; no children. For past seven years has suffered greatly during menstruation, but says what she lost has always been fluid blood with the exception of one occasion, about a year ago, when, after "missing" three months, and while at the water-closet, felt as if some small mass had come away. During the night before expelling the above cast, patient had had agonising pains for several hours. She had not seen anything for two months. The cast was the shape of the interior

of the uterus, and weighed about three drachms. It was of a soft, membranous consistence and easily torn.

DR. TRENHOLME thought, from the history of the case and from its appearance, it was the decidua of conception.

DR. GURD mentioned that the appearance exactly corresponded with what Dr. Thomas of New York describes as being a true membranous dysmenorrhœa cast, viz.: "External face soft and irregular, with perforations answering to opening of the utricular follicles. Inner face smooth, and feeling like mucous membrane."

DR. GARDNER said that it did not look like the product of conception.

The specimen was referred to Dr. Wilkins for microscopical examination.*

Ovariectomy—Removal of Pelvic Tumor containing Pus—Death forty-four hours after.—DR. GARDNER exhibited the tumor, and a bottle of the pus, which was odorless. Patient was unmarried, æt. 21, from the country, and with history of good health up to December last. Eight weeks ago became ill, feverish, and had repeated rigors. In the evenings would have a rigor and temperature of 103°. A tumor about size of gravid uterus, at fifth month, was noticed in the left iliac region, rounded, smooth, elastic, and not sore. She became emaciated. Her physician diagnosed a suppurated ovarian tumor. On examination, the uterus was felt anteverted and immovable. The sound entered 2½ in. Roof of vagina was

* The specimen submitted for examination was hardened in Muller's fluid. Sections were made with microtome; stained, some with picro-carmin and others with hæmatoxyline, and mounted. On examination, connective tissue, which is so sparingly present in the normal uterine mucous membrane, was found to be enormously increased in the specimen under examination; the hypertrophied condition being due to this, as well as to the unusually large number of mucous and lymph corpuscles imprisoned in its meshes. It contained also a few spindle-shaped cells. The basement membrane of the exfoliated uterine glands was considerably thickened, the glands being of normal size, and most of them containing cells undergoing degeneration. No increase in vascularity. No traces of villi could be found. The presence of uterine glands, and the absence of the usual changes in them associated with impregnation, also the absence of villi and of increased vascularity, prove that impregnation had not taken place and that the specimen under examination was a hypertrophied mucous membrane of menstruation, which was prevented, by the unusually large amount of connective tissue present, from undergoing the usual molecular disintegration associated with this function.

encroached upon by the growth. Operated last Wednesday; it was very tedious, as there were adhesions all around to the pelvis. By tapping, 32 oz. of odorless pus came away. Over the surface of the tumor was a much dilated fallopian tube. The hemorrhage was difficult to control. Patient died after 44 hours. It was either a dermoid cyst lighted up to activity or an ordinary ovarian tumor, the sac of which had suppurated.

Interrupted Menstruation.—DR. GARDNER said that lately he seen, in consultation, a lady, aged about 43, who has commenced menstruating regularly after an interval of 14 years. During her early married life she had three children, after which her husband became morally insane, was morose, and lost all affection for wife and children. She was obliged to leave him. The return of the flow excited fears of malignant disease or tumor. Examination showed nothing wrong except slight hyperplasia of the uterus.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Value of Single Symptoms in the Diagnosis of many Diseases of Childhood.

The *Medical and Surgical Reporter*, July 12th, reproduces editorially the substance of a paper by Dr. L. M. Politzer, for many years Director of the Public Hospital for Children in Vienna, which was recently published in *Deutsche Med. Zeit.*, May 19, 1884. The symptoms principally considered are the following:—

(1.) *If the cry of children has a decided nasal sound, we should always look for a retro-pharyngeal abscess. Whenever the cry of a child has this peculiar or guttural sound, we should never omit touching the posterior wall of the pharynx with our finger; if the abscess is present we feel the tense, fluctuating swelling so characteristic of retro-pharyngeal abscess.*

(2.) *A noisy expiration, which is greatly prolonged (ten to fifteen times), while inspiration is normal, and no other disturbance of breathing, no dyspnoea whatever exists, is a sure sign of chorea major, and the same can be said of a greatly prolonged,*

very loud, and forcible expiration, sounding like bellowing. This symptom of bellowing (brüllend) expiration has a typical character; it may happen for many weeks daily at one and the same hour, recurring every seven to ten seconds, and it usually consists of a single prolonged and forced expiration, or of a single expiratory roar. For months sometimes this symptom is the only sign of chorea major. It is easily cured by large doses of quinine, but is very prone to relapse and to be accompanied by other symptoms of chorea major.

(3.) *The symptom of high-thoracic, continually sighing inspiration* indicates the beginning of debility and paralysis of the heart. Ere cyanosis or paleness of the face, a weak, thread-like pulse, and coldness of the face, of the nose, and of the extremities develop themselves, this symptom makes its appearance. Contrary to stenotic respiration, as observed in croup, pneumonia, and œdema of the glottis, this sighing inspiration is not characterized by forced contractions of the diaphragm, and is not of abnormal type, but is accompanied by a laborious rise and fall of the thorax and jugulum, and instead of a stenotic noise by continuous sighing and moaning. No matter how the paralysis of the heart may be produced,—whether by so-called heart-poisons, as quinine, salicylic acid, pilocarpin, and digitalis, or otherwise—the symptom just described is pathognomonic of the disease, and whenever met with precautionary measures to combat the threatening palsy of the heart should be at once resorted to.

In some cases of acute fatty degeneration of the heart the same symptom has been observed.

(4.) *Expiration, decidedly diaphragmatic, and accompanied by a whistling sound of high pitch*, denotes bronchial asthma. A similar symptom is also met with in croup; but here it is associated with stenotic, forcible inspiration. The same is observed in capillary bronchitis; but the noisy breathing through the nose, the rapid development of pulmonary emphysema, the sudden appearance and disappearance of intense dyspnoea, and the fact of the latter and the whistling remitting during sleep, will prevent error.

(5.) *The existence of noticeable pauses between the end of each expiration and the beginning of the next inspiration indicates severe catarrh of the larynx, and proves the absence of croup.*

In consequence of the enormous aspiration of air in croup, inspiration and expiration follow each other immediately, while in laryngeal catarrh a pause takes place between the two acts, as the physician can convince himself by bringing his ear near the mouth of the patient, or by carefully watching the diaphragm and the jugulum, both of which are at rest during a pause.

(6.) *So-called stridulous expiration, if present at birth and continuing day and night with rare interruptions of ten or fifteen minutes's duration, and usually considered by anxious mothers and the uninitiated a dangerous and ominous symptom, has neither diagnostic nor any other importance, being perfectly innocent, and generally ceasing of its own account after the lapse of a few months.*

Then there are certain symptoms enabling us early to recognize various *diseases of the brain* in children:—

(1.) *A remarkable drowsiness, not accompanied by fever or any other symptom, and continuing for a longer time (one to three days), often precedes basilar meningitis.*

Vomiting, fixed pain in the head, even a slow, irregular pulse, have not the same great significance as this sleepiness, as they may also happen in other maladies. Certainly, stress must be laid upon the absence of fever, for many infectious diseases begin in children with a peculiar drowsiness, always associated, however, with more or less high fever.

(2.) *Prominent anterior fontanelle, if decidedly reaching above the level of the surrounding parts, and if tense and of such a resistance as not to yield under pressure, proves the presence of an exudation within the cranium, or an increase of the contents of the latter, and is met with in purulent meningitis of the convexity, in cerebro-spinal meningitis of the epidemic variety, in acute, essential and chronic hydrocephalus (here tense, but not necessarily very prominent), in great tumors, in echinococci, in acute oedema of the brain, and in intermeningeal*

apoplexy. In simple congestion, in acute hyperæmia of the brain, the anterior fontanelle always is soft and depressible. If the fontanelle is very prominent, almost cuneated and unyielding, without the least trace of pulsation, the diagnosis of apoplexy of the new-born, and a large intermeningeal extravasation of blood, can be made with certainty.

(3.) *Remarkably slow motion and long fixation of the pupils with a vague look into vacancy, accompanied by a peculiar, slow opening and closing of the eyelids,* is a sign of beginning basilar meningitis.

Next, *peculiarities of the cry of children* aid us in the diagnosis.

(1.) *Violent, loud, penetrating crying, lasting two or three minutes, accompanied by great anxiety, as expressed in the face, and setting in almost typically, one to one and a half hours after the child has fallen asleep,* is a symptom of nightmare, and easily cured by quinine, which, in the dose of five to eight grains, should be administered one or two hours before retiring.

(2.) *Periodical crying, lasting five to ten minutes, and happening several times in the day, but occasionally only at night,* draws the attention to spasm of the bladder, if colic or dyspepsia is not present, and is cured by an emulsion of lycopodium, with or without belladonna.

(3.) *Frequent crying during defecation, dread of the act, and decided opposition of the child to going to stool,* indicate the existence of fissure of the anus. Constipation should be avoided in such cases, and zinc-ointment, with belladonna, locally applied.

(4.) *Violent, very painful, and nearly continuous crying, with restless throwing of the head from side to side on the pillow, and frequent grasping of the head by the hands,* are generally indicative of otalgia and otitis media and externa.

(5.) *Crying, lasting days and weeks, greatly increased on touching or moving the extremities,* accompanied by continuous, enormous perspiration and fever, denotes the presence of acute general rachitis, while the same symptom, without the sweating, but with decided emaciation, proves the existence of hereditary syphilis, and that the case is hopeless.

Of a great number of other symptoms we will mention but the following, as they are of more common occurrence and of greater importance :—

When children are remarkably weak and little inclined to moving about after apparently innocent complaints of very short duration, *spinal infantile paralysis* may be expected. The least disturbance of hearing after acute diseases must be carefully inquired into, as it might be caused by *circumscribed meningitis* at the base of the fourth ventricle. Depression of psychical activity in small children after grave infectious diseases frequently forms the commencement of *acquired idiocy*; here strychnine has been proven by experience an invaluable remedy. Ossification of the bones of the cranium postponed longer than normal denotes beginning *rachitis*. An anxious, stiff action in walking, sitting, rising, etc., and pain expressed in the face of children, who do not yet walk, when they are lifted or laid down, are met with in the commencement of *spondylitis*. When children with a very large, closed cranium for weeks vomit everything they eat, we have the proof that acute hydrocephalus is being added to the former chronic disease.

Excellent Advice regarding the Use of the Catheter.—The use of the catheter is in itself, to some extent, an evil; a very slight one if properly conducted, capable of becoming considerable in careless or unwise hands. A catheter is, therefore, only to be employed when the evil which is to be removed by its means may be regarded as more grave than that which is incurred by using the instrument; and such conditions as these are daily presented in practice. Let, then, every instrument employed be that which can be most easily passed, and is made of the least irritating material; always of course consistently with the efficient attainment of the object in view. Thus metallic or rigid instruments, as a rule, should only be used when those which are soft and flexible have failed; and for whatever purpose, they should not be larger than the needs of each case demand. By such gentle treatment a very considerable improvement in most cases is certainly attainable; and in the course of time the greatly exaggerated

antipathy which widely exists to the use of instrumental treatment in the bladder will gradually but certainly disappear. I have one more caution to utter in regard of habitual catheterism, for those elderly patients whose circumstances have been above referred to; which is of great importance. When the bladder has for a long period of time been over-distended—the patient's condition having been overlooked for months, or even for years, in consequence perhaps of catheterism having been forbidden—it is, at this advanced period of the case, a serious matter to resort to it. Rashly undertaken, great as is the relief at first experienced, symptoms of fever—"urinary fever," as it is, I think, properly termed—often appear in a few days; cystitis occurs, catheterism is required more frequently, the urine becomes highly purulent, the powers of life feeble, the tongue dry, nourishment is refused, and the patient sinks—usually in about three or four weeks from the first employment of the instrument. If a necropsy be made, almost invariably the ureters will be found dilated on one or both sides; one of the kidneys diminished in bulk, and wasted, the other enlarged, inflamed, and perhaps the seat of numerous deposits of pus. It is said that such fatal histories following catheterism for long-continued distension of the bladder have occurred in individuals whose urinary organs, when examined after death, are found free from organic disease. Far be it from me to state that such a sequence of events is impossible; but it must be one of great rarity. No example has occurred within the range of my experience. When a patient, whose vesical functions have been long impaired, requires artificial relief, the best chance of saving him is to enjoin at once the recumbent position in a warm and equable temperature, usually in his bedroom, in order that the skin may act freely, and that no locomotion may be possible. The catheter should be used skilfully and with great gentleness; not at first emptying the bladder completely, but always removing the instrument when pain is felt, as it often is before that condition is reached; and it must be applied again as soon as relief is manifestly required. I can scarcely over-estimate the value of these precautions, nor advise too

strongly the abstinence from movement and exposure of all kinds for a period of a few weeks in these particular cases. We may thus sometimes succeed in prolonging life, even at a very advanced term, and at the same time avoid the groundless but injurious opposition which is often manifested, as we have seen, to the use of the catheter; the want of which at an early period in the patient's history, and not the late recourse to it, has been the real cause of death in almost every one of the fatal cases described.—*Sir Henry Thompson's Lectures.*

Rabies in Birds.—Birds can, according to M. Gibier's showing, no longer be regarded as proof against rabies. As a rule, birds inoculated with the virus exhibit but few symptoms, or possibly none; but in a certain fowl it was observed that 14 days after inoculation paralysis of one of the legs and of some of the neck muscles set in. After some days the illness and paralysis passed away, and the bird continued to live. Acting on the notion that birds may contract the disease, but that, owing to the relative insensibility of their cerebro-spinal nervous system or from some other reason, the microbe may undergo its evolution without destroying life, inoculations were performed on a cock and pigeon with a drop of distilled water holding in suspension some cerebral matter taken from a rabid dog. The symptoms which resulted were anything but satisfactory. However, at the end of 12 days a small section of the brain of the pigeon was removed by trepanning. Microscopic examination revealed the microbe already described by M. Gibier. After this, inoculations were performed on three rats with the material taken from the pigeon's brain. All three rats perished with unmistakable signs of the disease. Similar investigations were attended with like results when the cock was the subject of the experiment. Another fact seems to have been brought to light. It is to the effect that the virulence of rabies in the cerebrum of the pigeon passes away after some months. We may also recall the researches made by M. Gibier on rats, which conclusively proved that neither garlic nor pilocarpin can stay the course of rabies.—*Lancet.*

Inheritance of Cancer.—In the course of a paper on the Local Origin of Malignant Growths (*British Medical Journal*), Mr. Jonathan Hutchinson observed: —“It is needful to say a few words as to the inheritance of cancer in its bearings upon the doctrine of its local origin, since an adverse argument has been founded upon it. It has been urged with much plausibility, that a disease which is capable of inheritance must be a constitutional one. No doubt, to some extent, this is true; but the argument must not be pushed beyond its legitimate scope. The laws of inheritance, as with property, so with disease, concern convection, and not origin or production. The inheritance of a fortune is a very different thing from its acquisition, and gives us no clue as to how that may have been accomplished. The causes of cancer, as we meet with it in practice, may, perhaps, be usefully classed as three—senility of tissue, local irritation, and inheritance. Of these, only the first two can rank as true causes; the latter, although practically of great importance, is only a mode of perpetuation of that which the other two have originated. Senility gives proclivity, local irritation excites, and subsequently hereditary transmission may perpetuate. The facts, as regards chimney-sweeps' cancer, give perhaps the best illustration of what I mean. Before this malady was practically suppressed by act of Parliament, it was commonly noted that when the trade of sweep went, as it often did, in a family, proneness to suffer from soot-warts, and for soot-warts to degenerate into cancer, increased in successive generations. Grandsons and great-grandsons were attacked at earlier ages, and with much greater frequency, than those who were new to the trade. Here, then, we observe the liability to a form of cancer, produced in the first instance by a local cause, perpetuated and intensified by hereditary transmission. We witness the genesis of cancer, and see the shares taken by local irritation and inheritance, and how entirely secondary the latter is as regards the former. If we ask what that is which is inherited in the case of the transmission of cancer, probably the nearest approach to an answer which can be given will be to say that it is a peculiarity in cell-structure generally; not germs, not a

blood-malady, but a special type of cell organization, permitting with greater ease than in other persons the injurious influence of local causes. Even in the sweep, whose forefathers have suffered from soot-cancer, the transmitted tendency still waits for the exciting cause; and the disease occurs, not in internal and, therefore, protected parts, but on the same part as it did in his great-grandfather, and under the direct influence of exactly the same cause. Not that I would for a moment doubt that, in some instances, the inherited proclivity may be so strong that it does not wait for the help of any exciting cause, but manifests its power in the production of a cancer which may be considered spontaneous. It is probably in this way that we ought to explain almost all cases of cancer occurring in very early life; and it may be the fact that, in a few of these, something more definite than mere tissue proclivity may be transmitted, possibly even germinal matter, especially in those cases in which the parent was the subject of the malady. Thus, then, although I fully admit that in the examination of our patients we must make large allowance for the influence of inheritance, I wholly deny that we can allow it rank as a true cause of cancer."

Closure of the Jaws and its Treatment.

Dr. J. Ewing Mears, of Philadelphia, in an able paper in the *Amer. Jour. of the Med. Sciences*, discusses the various operations which have been suggested for the relief and cure of permanent closure of the jaws and the objections urged against them. He then narates a case in which he operated in the following manner:—By division of the ramus of the jaw, about its middle, exsection of the condyle and division of the insertion of the temporal muscle, thus releasing the coronoid process and affecting its removal with the condyle—division of the masseter muscle at its points of origin—non-interference with the cicatricial band. By this plan he hoped to secure sufficient space for free movement of the remaining portion of the ramus, and he proposed to utilize the cicatricial band as a *quasi* ligament, and obtain movement of the bone between this band and the interior pterygoid muscle. By division of the masseter at

its point of origin, he proposed to relieve the tension of this muscle and more effectually prevent union of the divided fibres. The plan of operation suggested and practised is novel, in the fact that it includes removal of both coronoid and condyloid processes with the upper half of the ramus, as well as division of the masseter, external pterygoid and temporal muscles, at the point of origin of the former, and the insertion of the latter. The advantages claimed over other methods are:—1. Its application to all forms of permanent closure, that due to temporo-maxillary ankylosis, as well as to cicatricial formations. 2. The utilization of the entire body of the jaw in opening the mouth, not only affording in this way greater advantage in mastication and articulation, but serving to prevent deformity. 3. The formation of a more perfect artificial joint in the removal of both processes, thus overcoming the resistance of the more or less fixed upper segment, when the joint is made either in the body or the ramus of the bone.—*Medical Digest.*

Apomorphia for Foreign Bodies in Air Passages.—Patient, aged 27, admitted to hospital with the following history: Ten weeks ago, while eating soup, was suddenly seized with a severe attack of coughing and dyspnoea, which lasted for several hours. They gradually diminished until patient was comparatively comfortable, but still dyspnoea and some cough remained. Such has been his condition since, the cough and shortness of breath being increased by exertion. Physical examination revealed a space about as large as the hand just under angle of right scapula dull on percussion, and on auscultation yielding crackling râles and an expiratory murmur. Signs also of general peritonitis over both lungs. Patient placed on apomorphia gr. 1-16 every four hours, and during the third night following the inception of the treatment, in an attack of coughing, the patient expelled a piece of bone about the size of a lentil or split pea, and which was the cause of the trouble. Prof. Ebstein said this was the third case in which apomorphia in his hands had caused the expulsion of foreign bodies in the air passages. He gave us no explanation of its special fitness for such cases, but recommended it very highly.—*Ebstein's Clinic. (Cincinnati Lancet & Clinic.)*

Seven Common Surgical Follies.—Dr. John B. Roberts, of Philadelphia, in a paper read before the Westchester Medical Society, and published in the *Polyclinic*, points out what he holds to be follies in connection with seven surgical procedures. He calls them the ether folly, the incision folly, the sponge folly, the styptic folly, the suture folly, the adhesive plaster folly, and the dos efolly. The ether folly is almost universal. It consists in allowing the inhalation of atmospheric air with the vapor of the ether, as it is proper to do when giving chloroform. In giving ether the napkin holding it should not be removed from the patient's nose and mouth. When it is necessary to replenish the anæsthetic the corner of the napkin should be turned up and a fluid ounce of the ether dashed upon it, or it may be poured on the outside of the napkin and covered with a large dry towel. The pure ether vapor must alone be inhaled to secure its best effects. The only exception to this rule is when blueness and congestion of the face occur as a result of spasm of the respiratory muscles. Usually one deep inspiration will be sufficient to relieve this, when the napkin should be immediately replaced. Squibb's ether is in no way superior to that of other reputable manufacturers.

The incision folly consists in making a cramped cutaneous incision, instead of one sufficiently large to fully display the tissues needing examination. A cut of the skin three inches long is no more dangerous than one two inches long. In opening abscesses a free cut is more satisfactory than the mere puncture or button-hole incision.

The sponge folly consists in the employment of sponges which have done previous service. They are seldom or never properly free from septic matter. To obviate this danger, napkins or towels are to be employed instead of sponges. Japanese paper napkins answer a very useful purpose. Absorbent cotton is valuable but it is expensive, and besides it is apt to leave filaments entangled in the wound.

The styptic folly is also a very common one. Alum, tannin, and that vilest of all styptics, Monsel's solution, prevent or delay union by first intention by irritating the edges of the wound

and preventing their coaptation. Except when a large vessel is severed, pressure is all that is demanded. When such a vessel is divided, ligation, torsion or a cupressure should be employed, but under no circumstances styptics.

The suture folly. The old idea that sutures should not be employed in the scalp has been long exploded, but still another folly exists in connection with sutures, and that is that silver wire only should be employed for suturing purposes. Iron wire is equally valuable and much less expensive. A nice iron wire can be bought for five cents a spool. If it becomes a little rusty, it can be rubbed clean in a moment should the operator object to the presence of a small amount of oxide of iron in the wound.

The adhesive plaster folly is prevalent. The envelope of a stump or the covering up of an incision with adhesive plaster prevents drainage, is uncleanly and does no good. Adhesive plaster has little or no value in surgery, except for making extension and preventing motion in cases of fracture.

Sponges, styptics and silver wire are useless and worse than useless, and their banishment will be a long stride in the progress of surgery.

The dose folly consists in the exhibition of an insufficient quantity of medicine. It should more properly be called the *small* dose folly. Of what use is a sixteenth or an eighth of a grain of morphia to a man in severe pain? Give him a quarter or even a half grain, and repeat if necessary. And what is true of morphia is true of all other drugs—quinine, atropia, strychnine, digitalis, mercury, pilocarpine, etc.;—they must be given with a bold hand to produce effect. First, be sure of your diagnosis and then go ahead. Many surgeons fail to cure because of the tentative use of drugs which comes out of uncertainty of diagnosis.—*Med. Age.*

The Treatment of Abortion.—Dr. Macan, in his recent report of the Rotunda Hospital, states that during the year 16 cases of abortion were admitted to the hospital. The treatment was expectant as long as possible, and in none was the vagina plugged, but in case of excessive hemorrhage before

the cervix was sufficiently dilated to allow removal of the ovum, the cervix was plugged with a tupelo tent, or dilated with Hegar's instrument, and the ovum removed. When any part of the ovum remained, causing putrid absorption or hemorrhage, the uterus was well washed out with the corrosive sublimate solution, the curette used, and then the corrosive sublimate again, and in septic cases, in addition, an iodoform suppository was introduced. The record of Dr. Macan's practice is a contribution to the subject of the proper management of inevitable abortion, a topic that has attracted much attention in recent years in this country. The profession, in fact, is yet divided in opinion, some advocating immediate and active interference—attacking *vi et armis*, that is with big and little curettes—and emptying the uterus as promptly as possible; while others more conservative, or at least less radical, prefer an expectant course, letting their action depend upon events, persistent or severe hemorrhage, or an offensive discharge, being signals for immediate evacuation of the uterus.—*Medical News*.

Trephining for Epilepsy with Delusions.—Dr. Frank Warner, of Columbus, Ohio, reports the following case in the *Cincinnati Lancet & Clinic*: Four years before his application for treatment for epilepsy John W. had fallen from a scaffold, and, as he struck below, the occipital bone was penetrated by a nail which was protruding through a board. A short time afterward he became affected with epilepsy, pain in the head over the seat of the fracture, which was just to left of the mesial line, in the occipital bone, and an inch below the articulation of this bone with the parietal, and after a while developed peculiar nervous symptoms, becoming irritable, easily excited, and manifested occasional delusions. At first, symptoms were mild, the epileptic attacks occurring once a month, and then, perhaps, one slight convulsion ending the manifestation of the disorder. In the first two years little change was manifested, but gradually the epileptic seizures became more frequent, and instead of one or two convulsions ending the attack, three to six would follow in quick succession. Occasional delusions took possession of the patient, and he imagined persons designing

evil things against him, frequently prepared to protect himself by carrying dangerous implements. Trephining was done over the point where the nail had entered the skull, and three buttons removed, the reason for taking out more than one being that fragments from the inner table could be felt, which we thought proper to remove. Pressure on the brain from the depressed bone was very slight, but the ragged edges were sufficient to keep up a continuous local meningeal inflammation. The patient made a rapid recovery, and for two or three weeks none of the old symptoms presented themselves, then a number of convulsions followed, with the characteristic delusions. These, however, soon passed away, and he made a rapid, complete, and permanent cure, four years having now passed since the operation, and the patient continues in perfect mental and physical health.—*Amer. Practitioner.*

Persistent Omphalo-mesenteric Remains ; THEIR IMPORTANCE IN THE CAUSATION OF INTESTINAL DUPLICATION, CYST-FORMATION, AND OBSTRUCTION.—The pouch-like formation of intestine occasionally seen projecting from the lower portion of the ileum is universally known as Meckel's diverticulum. Not that this distinguished anatomist was its discoverer, but to him we owe not only the almost universal acceptance of his theory of the origin of the pouch in question, but are also indebted to him for calling conspicuous attention to its importance in the causation of serious disease. In an instructive and elaborate article in the July number of the *Amer. Journal of the Med. Sciences*, Dr. Reginald H. Fitz of Boston considers this whole subject and points out that the view—that most, if not all, well-authenticated instances of duplication of the intestinal tract, at any part of its course, are the probable result of the persistence and growth of the remains of the vitelline duct—is rendered highly probable from what is known concerning the development of the intestine. Attention is also called to cystic dilatation of the diverticulum. These retention cysts, as they are called, may have their cavity continuous or discontinuous with the intestine. Moreover, such cysts of possible intestinal origin are not limited to the abdominal cavity, having

been observed in the vicinity of the œsophagus, in the abdominal walls, in the vicinity of the umbilicus. The clinical importance of these cysts is duly considered. Dr. Fitz points out that the vitelline duct is composed not only of layers of tissue equivalent to those forming the coats of the intestine, but it is also accompanied by blood-vessels. The relation of these omphalo-mesenteric vessels or their remains to intestinal strangulation is fully discussed, and the importance of bearing in mind the congenital nature of certain of the cases of acute intestinal obstruction is earnestly insisted upon. Dr. Fitz finds that—

1. Bands and cords as a cause of acute intestinal obstruction are second in importance to intussusception alone.

2. Their seat, structure and relation are such as frequently admit their origin from obliterated or patent omphalo-mesenteric vessels, either alone or in connection with Meckel's diverticulum and oppose their origin from peritonitis.

3. Recorded cases of intestinal strangulation from Meckel's diverticulum, in most instances at least, belong in the above series.

4. In the region where these congenital causes are most frequently met with, an occasional cause of intestinal strangulation, viz., the vermiform appendage, is also found.

5. It would seem, therefore, that in the operation of abdominal section for the relief of acute intestinal obstruction not due to intussusception and in the absence of local symptoms calling for the preferable exploration of other parts of the abdominal cavity, the lower right quadrant should be selected as the seat of the incision.

The vicinity of the navel and the lower three feet of the ileum should then receive the earliest attention. If a band is discovered, it is most likely to be a persistent vitelline duct—*i.e.*, Meckel's diverticulum, or an omphalo-mesenteric vessel either patent or obliterated, or both these structures in continuity. The section of the band may thus necessitate opening the intestinal canal or a blood-vessel of large size. Each of these alternatives is to be guarded against, and the removal of the entire band is to be sought for, lest subsequent adherence prove a fresh source of strangulation.—*Maryland Med. Journal.*

CANADA

Medical and Surgical Journal.

MONTREAL, AUGUST, 1884.

CREMATION.

The recent decision of Mr. Justice Stephen, whereby cremation is made legal in Great Britain, has naturally given fresh hope to those in all parts of the world who are in favor of that method of disposing of the dead. The fact of the eminent Prof. Gross having ordered his remains to be treated by cremation will also doubtless cause the practice to "boom" somewhat on this side of the Atlantic. It is true the cremationists have had a reverse or two lately. Thus in the British Parliament a bill proposed to regulate cremation and place it under proper restrictions was recently negatived by nearly two to one. Then the other day the Chairman of the Health Exhibition Committee, who, forsooth, does not approve of cremation, refused to give the "votaries of ashes" a stall at South Kensington. "May we live to see him cremated! (after death)," says the editor of the *Pall Mall Gazette*, and so say we.

We make no secret of it that we are strong advocates of cremation, and sympathize heartily with those who are striving to overcome the prejudices which have been raised against it. The vast majority of those who oppose cremation are of the sentimental class, and with them argument is out of the question. They shudder at the thought of their precious remains being subjected to such a process, but have no hesitation in allowing them to become the hiding-place of worms, while undergoing the slow process of decomposition which obtains from the ordinary earth system of disposal. These are, if anything, more determined in their opposition than the class who object to cremation on religious grounds. With the latter we

can have some patience, and perhaps a little sympathy. They argue that the burning of the dead is "foreign to the customs, and antagonistic to the genius, of Christianity." They mean, in other words, that it savours of disbelief in the cardinal doctrine of the Resurrection, besides contradicting all reference to the disposal of the dead in the sacred writings. Of course it is impossible to ignore this aspect of the subject, and in fact it would not be wise to do so. But, after all, what practical difference can it make whether the elements of which our bodies are composed are liberated in a rapid and cleanly way by fire, or slowly in the earth? The chemist will tell you that the processes amount to the same thing in the end.

But we advocate cremation as we advocate all measures of a sanitary nature. It has been proved over and over again that the dead are often a source of peril to the health of the survivors, and of course the danger increases with the number of the dead and the growth of the population. Thus wells and springs in the neighbourhood of cemeteries are liable to become contaminated after a time, giving rise to diarrhoeas and probably diseases of a typhoid nature. Besides, as cities extend, the places of burial have to be disturbed, and it is well known that certain soils have a preservative rather than a disintegrating action, so that after many years, in old and abandoned cemeteries, there will still be many bodies only partly decomposed. These, when exposed, must contaminate the air and originate disease. In our own city, within our recollection, two graveyards have been opened up and emptied of their contents, and before another half century has passed the present places of burial will be also threatened. What a mistake it is for a man to imagine that he is going to his last resting-place when he is buried! His bones may be disturbed half-a-dozen times before they crumble and disappear. Even the grave of the immortal Shakespeare is threatened with desecration, and simply to gratify an idle curiosity.

Now, cremation has none of these objections. It is a rapid and cleanly process, and the health of the survivors is not imperilled in any way. It is not much more expensive than ordinary

burial, and if it became more generally employed would be much less costly. At the Milan crematorium the charge made is only fifty francs, and where can one get a lot in a fashionable part of either of our Montreal cemeteries for an equivalent sum—ten dollars? The charge for cremation at the Boston crematorium is twelve dollars.

The only serious objection to cremation is the legal one; and to meet it, we must admit, is not easy. But it is not insuperable. Some system of preliminary examination would have to be devised, whereupon a sworn certificate could be given in every case of death. In cases of difficulty or doubt a *post-mortem* examination should be enforced. This might necessitate the appointment of a competent pathologist and chemist in connection with each crematorium. The ashes could be reserved for a certain time in every case, as it is stated that some of the mineral poisons are not destroyed during cremation.

VICTORIA-LAVAL.

It will be remembered that, at the last meeting of the Provincial Medical Board, Dr. Lachapelle, a member of the Board and a professor in Laval University, repeated formally certain statements which had already appeared in one of the local papers. These statements were to the effect that, at the time of the written examination held by the Medical Faculty of Victoria College, certain of the examination papers had found their way into the possession of some of the students several days prior to the examination. *Prima facie* evidence that this had actually occurred was furnished by the fact that on the 28th March Dr. Lachapelle placed in the hands of Mr. H. R. Gray documents purporting to contain the questions which would be given at the final test. The examination having been held on the 31st of the same month, these and the actual papers were published side by side. Their similarity was unquestionable. The gravamen of the charge, moreover, lay in the fact that it was further stated that these papers had been furnished to students by professors. Dr. Lachapelle requested the Board to apply to the Legislature for a Royal Commission, averring that before such

a tribunal, competent to take evidence under oath, he would produce evidence which, he believed, would prove the truth of his charges. At the meeting, Dr. Hingston, on the part of the Victoria College, admitted that, in some way (to them unknown), papers had been (presumably by fraud) possessed by students in anticipation of the examination. He stated that his school had already named a committee of its members who were not amongst those pointed at, who were then engaged in an investigation of the matter. They had, however, up to that time arrived at no result, but he thought a very short time longer would enable them to discover the guilty parties. Dr. Howard wished the matter relegated to this committee for further action. The meeting would not entertain the proposition for a Royal Commission, but decided to add to the committee above-mentioned all the governors of the College resident in the city and district of Montreal to continue the *enquête* already begun. This joint committee has now held several meetings, and has dispersed without having come to any conclusion. Repeated attempts were made to induce Dr. Lachapelle to make specific charges against certain of the professors and to give up the name of his informant. This he always declined to do, claiming that, in the first place, the committee having no power to summon witnesses or to oblige them to testify, he might not be in a position to substantiate his charges and would thus leave himself open to an action for libel; and that, in the second place, he was bound by a promise of secrecy which was inviolable except before a court of law. He persisted, however, in declaring his readiness to testify upon all these points if allowed a Royal Commission or other tribunal having similar powers.

It will thus be seen that the efforts of the committee have been futile, owing to their inability to secure evidence. The matter, therefore, was left just where it was before. The only other means left for the Victoria School to clear itself from these grave accusations was for implicated professors to institute suits against Dr. Lachapelle for libel and defamation of character. This, we are informed through the daily papers, has already been done in the names of Drs. D'Orsonnens and Mignault. It may appear

the proper thing that the President and the Secretary should be those selected to come forward as prosecutors in this action; but, perhaps, it would have been evidence of a stronger feeling of the strength of their case if the examiners most severely implicated had stepped first into the field. All interested in the good name of our provincial universities, and in maintaining a proper standard for those degrees which carry with them the license to practice, will look to the trying of these cases to establish clearly the rights of the whole affair.

CANADA MEDICAL ASSOCIATION.

Everything points towards a very successful meeting of the Canada Medical Association in Montreal on the 25th inst. In answer to the invitation extended by the local committee to the medical members of the British Association, twenty-three have already expressed their intention of being present at this meeting and at the dinner on the 26th. Amongst these are a large number of well-known writers and scientists. Over seventy members of the Canada Association have replied to the Secretary's circular saying they may be expected to arrive. The number of papers is considerably larger than usual. The list, so far, is as follows (others, no doubt, will come in later) :—

1. Dr. Fenwick, Montreal Abscess of Abdominal Parietes extending from Meckel's Diverticulum.
2. Dr. Gardiner, London..... Burns and their Results.
3. Dr. Fulton, Toronto Thoraco-plastic operation of Estlander.
4. Dr. Shepherd, " Compound Fracture of the Leg—Rupture of the Anterior Tibial Artery—Ligature—Recovery. And An Obscure case of Popliteal Aneurism.
5. Dr. Blackader, " A case of Congenital Lipoma. And Recent Advances in Infant Feeding.
6. Dr. Rosebrugh, Hamilton.... Recent Progress in Abdominal Surgery.
7. Dr. O. C. Brown, Actonvale....
8. Dr. Oldwright, Toronto..... Myxo-Sarcoma. (Sequel to last year's paper.)
9. Dr. Campbell, Seaforth..... Puerperal Septicæmia.
10. Dr. Ryerson, Toronto..... Post-nasal Catarrh.
11. Dr. Buller, Montreal..... Jequirity in Granular Ophthalmia.
- Dr. MacDonnell, Montreal.... Exhibits Medical Cases.
- Dr. Gurd, Montreal..... " " "
12. Dr. Major, Montreal..... Recent Progress in Laryngology.
13. Dr. Osler, Montreal..... Pneumonia as an Infectious Disease.
14. Dr. Dupuis, Kingston..... Nostrums and Medical Advertising.
15. Dr. H. Howard, Montreal.... Materia Cogitans.

16. Dr. Harrison, Selkirk..... Cerebro-Spinal Meningitis.
17. Dr. Lett, Guelph..... Opium Habit and its Treatment.
18. Dr. Burnham, Toronto..... The Use of Carbolic Acid in some of the External Diseases of the Eye.
19. Dr. Marsden, Quebec..... Asiatic Cholera.
20. Dr. R. P. Howard, Montreal.. Some of the varieties of Dyspnoea met with in Bright's Disease.
21. Dr. Desjardins, Montreal..... Feratoscopie, comme moyen de diagnostic dans l'astigmatisme.
22. Dr. Bethune, Wingham..... A peculiar parasite found in an abscess of the thigh.
23. Dr. Worthington, Clinton, Ont. Reports of two cases of Diabetes Insipidus, one of which was complicated with Exophthalmic Goitre.
24. Dr. Gardner, Montreal..... Common Errors in Gynæcological Practice.
25. Dr. Playter, Toronto..... The relations of the Medical Profession with the Public.
26. Dr. Roddick, Montreal..... Surgical Jottings.

It would be well for those who are coming to remember that, just at that time, the hotels will be crowded. They should secure accommodation by telegraph in advance, if possible. As we have already stated, the usual reduced rates have been secured from all the leading steamboat and railway companies. Certificates of membership for securing these can be obtained by application to Dr. James Bell, Montreal (acting General Secretary), or through any of the local secretaries, whose names are as follows:—Dr. Bray, Chatham; Dr. Coleman, St. John, N.B.; Dr. Black, Halifax, and Dr. Betts, Winnipeg.

THE BRITISH MEDICAL ASSOCIATION assembled at Bedford on the 29th of July. With its usual enterprise, the *N. Y. Medical Record* contains in its issue of the 2nd of August a cabled report of the proceedings. Dr. Canning, the President, gave an address, referring to the present epidemic of cholera in Europe and referring to the importance, in consequence, of the sanitation of cities. The subject of micro-organisms and their relation to disease was next considered. He then dwelt upon the advantages to be expected from the newly-erected section on Pharmacology and Therapeutics. The following day Dr. Lewis A. Sayre, of New York, gave a demonstration of the application of the plastic jacket in diseases of the spinal column. D. Ord, of London, delivered the address on Medicine. His subject was "Some Perversions of Nutrition caused by the

Nervous System." Sir Wm. MacCormac delivered an address on "Abdominal Surgery," reviewing the advances made in that department during the past few years. In the section on Medicine, Dr. Geo. Johnson opened a discussion on "Albuminuria, its Causes, Consequences, Diagnosis and Treatment." A letter was read from Sir Andrew Clark, in which he divided the non-functional forms of albuminuria into four varieties—hepatic, oxaluric, gouty, and nervous. The same number of the *Record* contains the address on Physiology by Dr. Peter Redfern, of London. Dr. Geo. H. Kidd delivered an address on Obstetric Medicine. The President addressed the meeting on "The General Character of Epidemics." In the course of his remarks he referred to the prevalence of cholera on the continent, and urged due vigilance on the part of the profession and government of Great Britain against the invasion. Nothing was of more importance than the purification of the drinking water, attention to perfect sewerage and the free use of disinfectants. In fact, the purer the water of a district the lower was the death-rate. The labors of Pasteur, Budd and Koch were appropriately referred to and eulogized. In the section on Medicine, Dr. Douglass Powell introduced a discussion on the causative relative relations of phthisis. His line of argument was against the contagiousness of the disease. Dr. Dyce Duckworth introduced the subject of "Rheumatoid Arthritis." Dr. Shoemaker, of Philadelphia, presented the subject of the "Oleates," and urged their further study. The *Record* of the 9th inst. contains Dr. Kidd's address in full.

SPECIFIC TREATMENT OF DIPHTHERIA.—We took occasion to refer to this subject a short time since, and return to it just now to add the experience of a recent writer in the *Medical News*, Dr. Geo. A. Lynn, of Pennsylvania. The drug which seems to promise the best results, considered both theoretically and experimentally, is the corrosive sublimate. The conclusions of Dr. Lynn are that, to use the remedy as a specific, 1st. It must be given in the first stage of the disease; 2nd. It must be given in large doses, frequently repeated. It is claimed for it that, used in this way, it mitigates the severity of all the general

symptoms, "prevents the generation of the poison in the membrane, in mild cases checks the formation of membrane at once, and causes what is formed to speedily disappear." It is best given in solution, and the vehicle preferred is the elixir of bismuth and pepsin. The dose recommended is, for a child three years old, gr. 1-16, or, in a malignant case, gr. 1-8, in a teaspoonful of the elixir every three hours; for an adult from gr. 1-12 to gr. 1-8 every three hours. "It rarely disturbs the stomach, and soon allays existing nausea." It is advised that, if the case be far advanced before being seen, brandy and iron be added to the treatment.

RUPTURED PERINEUM TREATED WITH ONE STITCH.—We notice in the July number of the *American Journal of Obstetrics* that Dr. H. J. Lee, of Cleveland, O., reports three cases of lacerated perineum treated by a single suture, as recommended originally by Dr. Alloway of this city. He says the ease with which the operation is performed and the perfect results given by Dr. Alloway are sufficient reasons to warrant a further trial, and, if found to result as perfectly in other hands, it surely should succeed the more complicated operation which appears so formidable to both physician and patient. Dr. Lee does not agree entirely with the originator of the operation on one point. Thus, while Dr. Alloway thinks that the suture may be passed "at any point between the beginning and the end of the laceration," he contends that the suture should always be passed "on a level with the beginning of the laceration." He compliments Dr. Alloway highly on his conception of the operation, and wonders that, being so simple, it was not thought of before.

FEES EXTRAORDINARY.—A dentist of New York of the name of Atkinson recently did four days' work arranging and filling teeth, etc., for General Blanco, the Venezuelan President, and family. The General expected to pay a pretty large bill, especially as other engagements had been postponed to suit his convenience, but he confessed to some surprise when an account was rendered him for \$7,000. A mutual friend suggested that there was some mistake, but this is indignantly denied. A compromise was offered of \$1,500, but it is understood that suit will be entered for the sum originally claimed.

FEMALE PHARMACISTS.—It may not be generally known that there exists in the United States a special school for the teaching of pharmacy to women. The institution is located in Louisville, Ky., and has recently held its first commencement, at which an address was given by Dr. Yandell. There is no doubt that this calling is one peculiarly fitted to women, and therefore it is much to be desired that the example set here will be extensively followed elsewhere. More employment, and more remunerative employment, is demanded for women of better education, and pharmacy would seem to supply one of these of the most suitable character.

PAINLESS SLAUGHTERING.—Dr. Richardson, always working in the direction of serving the best interests of both men and animals, has been further experimenting with reference to the use of anæsthetics previous to killing. He now advises the employment of carbonic oxide gas charged with the vapor of chloroform. Several hundred dogs have been painlessly put to death in this way at the Dogs' Home, Battersea, and Dr. Richardson suggests that the method should be employed in the killing of animals used as food.

—Dr. William Osler, of McGill University, Montreal, is prominently and favorably mentioned in connection with the Professorship of Clinical Medicine in the University of Pennsylvania, rendered vacant by the transfer of Dr. Pepper to the Chair of Theory and Practice of Medicine. Dr. Osler is widely known as a talented scholar, a learned clinician and a popular teacher, and his election, which it is understood will be very acceptable to the Medical Faculty, would add undoubtedly to the high reputation which the University has always enjoyed. Dr. Osler has just been invited to deliver, next spring, the Gulstonian lectures before the Royal College of Physicians of London, of which body he was elected a Fellow in May, 1883.

We take the above from the *Philadelphia Medical News* of the 9th inst. If Dr. Osler should finally accept this appointment, whilst recognizing its appropriateness, we could not but feel that his removal involved a serious loss both to McGill University and to this city.

THE "GAMGEE" SPONGES.—We have received from W. A. Dyer & Co. specimens of these admirable articles. This substitute for the ordinary surgeon's sponge is the invention of Mr. Sampson Gamgee, the British surgeon so well-known for his great success in dry-dressing of wounds. It consists essentially of a nucleus of cocconut fibre, around which is a layer of fine absorbent cotton. The whole is covered with a thin, pliable gauze. Many of them are used plain, as above described; others are made antiseptic at the moment of using by breaking a small glass pearl hidden in the heart of the sponge and containing thymol, eucalyptol, carbolic acid, or any other substance which may be desired. They are highly spoken of by the English medical papers, and, in these days of antiseptic boom, are sure to become popular at once. They can be obtained from the above-named firm.

Medical Items.

PERSONAL—We were pleased to receive a visit from Dr. J. B. Lawford, formerly of this city. Dr. Lawford has been for some time house surgeon of the Royal Ophthalmic Hospital, Moorfields. He has resigned that position and been appointed pathologist to the same hospital. He thinks it possible he may remain permanently in London.

DR. CÆSAR HENRY HAWKINS.—This celebrated surgeon, who has recently died at an advanced age, was sergeant-surgeon to Her Majesty the Queen for many years. He held the position of surgeon to St. George's Hospital for thirty-two years. He was also Examiner in Surgery of the Royal College of Surgeons, of which he was twice elected president.

—Prof. S. W. Gross brought a case of gumma of the breast before the class last season, which was interesting, both because of the infrequency of its occurrence and of its resemblance to malignant disease. Gumma of other parts of the body are met with almost every day in hospital practice, but it is extremely uncommon to find this manifestation of the syphilitic poison on the female breast. The patient, who was 28 years old, and appeared to be in good health, complained of trouble in the left breast. Examination showed a cake-like superficial tumor

involving the skin and subcutaneous connective tissue. The skin over the tumor was livid in color, and the nipple was retracted into it. These signs apparently pointed to superficial scirrhus. But from the absence of pain, and axillary involvement, as well as the history of a dissolute husband and three miscarriages, Prof. Gross concluded that it was a gumma. The woman was put on the mixed specific treatment, and the tumor disappeared in a short time.

—A paper on “The Economic Preparation of some Antiseptic Dressings,” by Signor Silvio Plevani, has been published in the *Gazzetta degli Ospitale*. He states that tow, which is a very cheap residual material, can be used for all surgical purposes instead of absorbent cotton, when prepared according to the following directions: Boil the tow for some time in lye made with wood ashes, or with a two per cent. solution of carbonate of soda; then wash it repeatedly in water. The tow thus deprived of grease is immersed in a ten per cent. solution of chloride of lime, and kept in it some hours, with occasional stirring, until it has become perfectly white. It is then washed thoroughly in pure water until the liquid squeezed from it is perfectly limpid; drying and carding complete the process.

—Experience, the greatest of all teachers, has demonstrated that, in a large number of cases, Cod Liver Oil is beneficial for a few weeks, that the patient improves upon it, gains flesh and strength, but, unfortunately, this improvement does not continue; right in the midst of flattering prospects the patient comes to a halt, ceases to gain weight, or otherwise improve. Physicians have experimented for years in their endeavor to overcome this objection; it has finally been accomplished by Drs. G. Overend Drewry and F. C. Bartlett of London, England, who, by means of pancreatine, have succeeded in perfectly digesting or hydrating the oil, thus giving to the profession cod liver oil in a perfectly assimilable form, overcoming the only objection to its continued use. This hydrated oil is christened *Hydroleine*, and after nearly five years of extended trial it has been extensively approved of.

MELLIN'S FOOD.—Dr. H. E. Deane, resident physician of Detroit Foundlings' Home, Detroit, Mich., says:—“During the year we care for a large number of infants. The mortality in our nursery has been lessened more than one-half since we commenced using Mellin's Food. Our babies never looked so well as at present.”