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CANADA  
MEDICAL & SURGICAL JOURNAL

JUNE, 1878.

CASE OF SUPPOSED TUBERCULAR DISEASE OF  
THE BRAIN.—RIGHT HEMIPLEGIA WITH  
COMA, FOLLOWED BY APHASIA.

PARTIAL RECOVERY.—UNDER THE CARE OF

GEORGE ROSS, A.M., M.D.,

PROFESSOR OF CLINICAL MEDICINE, MCGILL UNIVERSITY.

(Read before the Medico-chirurgical Society, of Montreal, March 22, 1878.)

J. D., æt. 28, medium size, spare but not emaciated, came under observation on the 10th of October, 1876, complaining principally of very severe pain in the head and weakness.

His family history shows a markedly tubercular diathesis—his father, mother and five brothers and sisters having all died of phthisis—one sister only now surviving.

He has had typhus and typhoid fever, and also yellow fever. He had a chancre four years ago. Careful questioning fails to elicit any indication of his having suffered from constitutional syphilis at any subsequent period.

He had been an in-patient of the Hospital in August last, suffering from frontal pain, which was looked upon as neuralgic. He got better of this and went home, but the pain soon returned as severely if not more so than before, and became accompanied at times by attacks of giddiness, so much so that he was more than once obliged to sit down in the street to recover himself. Has had frequent sensations of flashes of light passing in front of his left eye. Occasionally has felt a jerking sensation, last-

ing a few moments, in the muscles of the right arm, leg and side of the face. Has also observed diplopia on several occasions within two months.

Four days ago he had a chill, since which time he has had a great deal of pain in the head, forehead, buzzing in the ears, loss of appetite, vomiting, and diarrhoea, accompanied by a great feeling of weakness. At present he lies very quiet in bed, all his movements being very slow. The abdomen is flat, and muscles rigid; tongue clean and moist. When he vomits there is very little nausea either preceding or following. Breathing slow and irregular. Pulse is 40 per minute; respirations 10. There is much intolerance of light, and he always lies with his head turned away from the window; when the gas is lit he moans and complains. Sounds of any kind also annoy him considerably. He complains continually of being drowsy, but does not sleep much. I had his eyes examined by Dr. Buller, who reported the presence of double optic neuritis, and a small spot of hæmorrhage in the left retina.

*Heart and Lungs* healthy. Urine normal in amount and appearance and free from either albumen or sugar.

*Ordered* sodæ hypophos. gr. v.; ol. morrhuæ ℥ss. three times daily.

During several days subsequent to this there are noted a continued dull, heavy suffering look; continued pain in head,—increased by light and sound; pulse became slightly faster, being 56 on the 18th, whilst the respirations were 12. At this time he began taking a draught of chloral and pot. bromide, to relieve the persistent sleeplessness.

By *Nov. 2nd*, he was somewhat better, not quite so dull and drowsy. Pulse, 100; respirations, 17. Slight dilatation of the left pupil was noticed.

*16th.*—Has had a superficial pain over left brow, of a darting character; it is found that there is decided tenderness over the three branches of the 5th nerve, most marked over the supra-orbital. This condition lasted only two weeks, and is noted as absent on the 1st of December. He was now up and about.

*Dec 26th.*—A sudden giddiness under which he fell; the

usual head pain has since been unusually severe, on the left side over the brow. Pulse 72.

*Jan. 14th.*—Headache more or less continuous—felt principally in the back of the head—occasional vomiting, and habitual constipation.

During the months of January and February, nothing particular was noticed. He remained in the hospital, never having been well enough to be discharged. He walked about a good deal, ate pretty well, but did not gain in flesh. Some days had but little pain in the head, but on others suffered very severely. About the beginning of March a gradual but peculiar change was noticed to be coming over him. Seemed very quiet and very stupid. On being asked what he feels the matter, says he can't tell, but that he has a queer feeling all over him, at the same time his speech is somewhat thick, and he speaks in a hesitating manner. This condition persisted through the months of March and April, occasional headaches meantime having been very severe. It was only, however, towards the end of the latter month that *peculiarities* in his expressions were noticed, as though he did not make use of the proper words to convey the idea meant. Thus he told us one day that he passed a *nightmare* last night, and other odd expressions, but that was all; nothing like the miscalling of aphasia.

On *April 28th* pulse was 60.

*May 1st.*—Head pain was very severe; is very dull; pulse 50.

*2nd.*—Head pain very intense last night; had some morphia hypodermically; is very dull, cannot walk at all, but has no actual paralysis of any of his limbs. There is some loss of power in the muscles on the right side of the face, especially in the orbicularis palpebrarum.

For several days he had become increasingly dull and stupid without as yet any hemiplegia. On *May 6th*, could not be got to answer questions at all, and had incontinence of urine; was very restless at times, requiring to be watched and kept in bed.

*8th.*—Quite unconscious; will not open his eyes, or protrude his tongue; is continually rubbing his chin and yawning. Pulse 60, small and compressible; pupils equal, of medium size.

The paralysis of the right side of the face continues as before, but has not become at all more marked ; it is thought that he does not move his right arm and leg as freely as those of the opposite side.

9th.—There is now very decided hemiplegia of the right side. both motion and sensation being completely lost. Has been very restless and delirious all night. Is quite unconscious and passes all his evacuations beneath him.

10th.—Apparently worse ; quite unconscious ; is constantly hiccoughing ; takes no nourishment.

12th.—The report of this day says, " Patient sinking rapidly," and, indeed, we had every reason to think so. He remained almost perfectly unconscious, with a constant annoying hiccough. Pulse became quite rapid (120) with respirations 20. Temperature 100 3-5°.

14th.—Some improvement has taken place ; he has to some extent regained consciousness and has made some endeavours to speak, although he has not succeeded in saying anything intelligible.

16th.—Remarkable improvement ; understands all questions put to him, and some of them he answers quite rationally. He recognizes the faces of the doctors and students, and points out those he knows, but cannot at all remember their names, although previously they were quite familiar to him. When shown objects he almost certainly miscalls them, although he will recognize the right word if told him, and will express pleasure thereat. At the same time his speech is very thick, stuttering and often difficult. The paralysis persists. He now takes plenty of nourishment, and is constantly asking for milk. Has no headache, in fact, no pain whatever.

17th.—Patient is quite cheerful to-day ; understands all that is said to him, and is inclined to be jocose over it, making poor attempts at smiling owing to his drawn visage. But the expression of his face is remarkably changed from what it was before the commencement of his illness ; before, it was always dull, solemn, and giving the idea of one suffering constant pain. Now, it is free from all painful expression and ready to break into a full grin at the least approach to a joke.

He is markedly aphasic. The urine is high-coloured, specific gravity 1028, and contained a marked excess of urea.

28th.—Is now quite rational, and continues unusually cheerful; has no pain; still aphasic but not so much as on two days ago; speech a little thick. Has a good appetite, and sleeps well. Hemiplegia persists.

20th.—Very much better; speaks much more freely, and attempts to speak quite volubly. He is generally pulled up short in a sentence by finding the want of a *name*, all other words seeming to come to him much more readily. To-day he can move the right leg pretty well, but not the arm.

30th.—Steady improvement has continued. Has very considerable use in the leg, and power over the arm is also slowly returning. The aphasia has also been correspondingly disappearing, until now he can name almost any object without mistake, only occasionally using a wrong word. Articulation, however, is yet somewhat thick, and a little difficult.

From this time improvement was steady and continuous. He fed well, and slept well, and gained in flesh. Had no pain in the head or elsewhere, and was always contented and cheerful, inclined, perhaps, to be a little *silly*, but at the same time quite able to *argue* upon any point. A slight degree of hemiplegia remains, and his speech is still a little hesitating.

*Remarks.*—I have brought this case before the society on account of several very interesting clinical features presented by it. Of course the patient being still alive, as far as I know, no confirmation of the diagnosis has been possible, and it therefore cannot be considered certain.

First, as to the symptoms presented upon admission, and for some time after, there were intense pain in the head; marked intolerance of sound and light; a dull, lethargic condition; a slow pulse and frequent vomiting with constipated bowels. This had supervened after a history of cephalic neuralgia, and repeated attacks of severe vertigo lasting during several months. These marked cerebral symptoms pointed, I thought, either to cerebral tumour or abscess of the brain. With a view of getting the advantage of a knowledge of the condition of the fundus of

the eye, Dr. Buller was kind enough to examine him for me with the ophthalmoscope ; there was found to be double optic neuritis in a very decided degree.

As regarded the differential diagnosis between the two conditions—which of course is often very difficult—the points in favor of the former were the existence of an extremely marked tuberculous history, thus affording one possible inherited constitutional condition capable of causing them. And against the idea of abscess were the absence of any injury to the head, or caries of the ear-bones, or other possible cause. Another feature also favoring the supposition of tuberculous deposit was the fact that for some time past he had been steadily losing flesh without any specially obvious cause for so doing. Of *Syphilis* there was no suspicion after very careful enquiry. *Cancer* was excluded by his age and the absence of cancer anywhere else, so that a tolerably positive diagnosis of *Tubercular Tumour* of the Brain was entered. This diagnosis I still maintain, and would account for the relief of the symptoms subsequently obtained by supposing that the growth, instead of continuing to increase in size has been undergoing some process of dessication or cretification. Of course there is no doubt that such tuberculous masses may so become innocuous elsewhere, and if so why not in the brain ? On the other hand, it may be objected that if there be a tumour it may be of the nature of glioma or fibroid tumour. This objection, it is impossible to meet. My reasons for thinking it *probably* tubercular I have already given.

Next, as regards the comatose or paralytic attack, which has been described, my impression at the time was that the disease had extended so as to involve either by pressure or by secondary softening, important parts connected with the motor tract or centre of speech in the left hemisphere of the brain ; but when improvement set in and continued steadily to advance, until, from a condition of complete aphasia, speech was almost entirely restored, then it seemed more reasonable to suppose that the results witnessed had been produced through derangement of the vascular supply by thrombosis, and as this defect was removed through the collateral circulation, the cerebral functions were once more regained.

I would note that this case adds one more to the many which have been reported to this society, of aphasia with *dextral* paralysis, and as yet not one of aphasia with *left* paralysis has been brought forward, showing what is universally admitted that the immense majority of cases of aphasia are produced by injuries upon the left side of the brain. I trust that if any member meets with an example of this rare variety he will favor this society with a report of the case.

## ON TWO CASES OF PUERPERAL CEREBRAL EMBOLISM.

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

I bring these cases before this society on account both of their great interest and rarity. I am sorry that circumstances have prevented me from procuring more complete notes, but still I feel it my duty to place on record two cases of such a rare and interesting affection, even if an exhaustive narrative cannot be supplied.

CASE I.—In March, 1877, during the absence of the regular physician, I was called to attend a lady in her first confinement, whom I learned had suffered in childhood from severe chorea. During her pregnancy she had been attacked with chorea in a form so aggravated as at times to prevent her from walking. The labour was natural though tedious, lasting twelve hours. Slight hæmorrhage occurred after the removal of the placenta, however under suitable remedies the uterus soon contracted, and when I left, almost two hours after labour, she was going on very well. The next morning on visiting her I found that she was speechless and hemiplegic in her right side, and was informed that late the evening before (about six hours after labour) she had a faint and became speechless, and that soon afterwards she was found to be paralysed in her right side. When I saw her the only word she could say was 'Yes.' She was quite sensible and understood all that was said to her. She had no pain in the head. Pulse was 80, and temperature 99°. Examined heart, and found sounds normal. During the following week



she began to regain the use of her right leg, but her right arm was comparatively useless and she was still aphasic. Her own physician being now in attendance upon her I did not see her again for several weeks, and at that time she had quite regained the use of her right leg and was regaining the use of her right arm. Her speech was slow and indistinct, she paused often for a word, but never used a wrong one. She spoke like a little child learning to talk, and pronounced her v's and r's like w's. From this time I heard she gradually improved, and was after a time able to use her arm fairly well. I saw her last autumn in the country, seven months after her confinement, her speech was still slow and sometimes indistinct and thick. She said her right leg was as strong as ever, but that her right arm was still weak, and that she could not nurse her baby on that side.

CASE II.—Whilst in the country last July I was sent for to see a woman who had been confined some hours before by a resident female accoucheur, and was suffering they said from severe flooding. When I arrived I found that the flooding had ceased, the woman was pallid, restless, and almost pulseless, and the uterus was distended with blood-clots. I immediately introduced my hand into the uterus and removed the clots. The uterus contracted well, and no further hæmorrhage occurred. I ordered the patient to be kept warm and to have plenty of milk. The next afternoon when I left for town, the woman apparently was doing well. The week after I heard from her sister that she had had a fit and was not able to speak, and was paralysed in her right side. The week following this I again went to the country, and on visiting my patient found that she was rapidly regaining her speech, and that she was recovering the use of her right leg. Bed sores had begun to form in the right buttock, still she was apparently improving, pulse firmly strong and temperature normal. I examined her heart but could detect no murmur. There was no history of acute rheumatism. I might have mentioned before that this woman was about 36 years of age, and that this was her sixth confinement. She continued to improve for some days, but as I was informed, she was then seized with a second 'fit,' and died

comatose the following week. I was in town when she died, and did not hear of her death till some time after, and, of course, it was then too late to obtain a post mortem.

The history of the first case would naturally lead us to suppose that some disease of the heart existed, as it is well known that cardiac disease is a very common accompaniment of severe chorea. It is also a well-known fact that slight cardiac disease may exist and not be detected during life. Sir James Simpson\* reports a case of puerperal cerebral embolism in the eighth month of pregnancy in which contraction of the mitral orifice was present; this was detected only after the most careful examination, and confirmed some years after when the woman died of a second attack. It is probable in my first case that vegetations existed on the valves of the heart, and that one of these had been loosened during the exertion of labour, was afterwards set free, and found its way to the brain, or clots might have formed on the diseased valve, and parts of these broken off and sent into the circulation. It is well-known that during pregnancy there is an excess of fibrin in the blood, and that the blood even where no diseased valve exists, has a tendency to coagulate, so that where there is an affection of some of the valves of the heart during puerperal attack, it is not at all improbable that the tendency the blood has to coagulate is very much increased. The attack in this case came on very soon after labour. This is rather unusual, as in Dr. Barnes'† fifteen tabulated cases of embolism of the extremities after pregnancy the earliest came on the second day, and the latest seven weeks after labour. Formerly it was thought that a case of puerperal cerebral embolism was necessarily fatal, and Dr. James Simpson, in 1857, had never seen a case of recovery. Several cases of recovery are reported in the Medical Journals, and this I am happy to say will add another to the list.

In my second case the cause of the embolism is not so clear, and the termination was not so favourable. There was no history of rheumatism, and no heart disease. As I said before it is

\* "Edinburgh Medical Journal," vol. viii. p. 1855.  
 † Obstetrical Society's Transactions, vol. iv.

well known the blood of women in the puerperal condition is more liable to coagulate than in ordinary cases. Dr. Austin\* says, "It is undoubted that in certain cachectic conditions and in certain states of the circulation, spontaneous coagulation of the blood takes place in the very centre of the propulsion, and it can hardly be far-fetched to assume that similar coagulations under certain circumstances occur at the extremes of the arterial system. Now, this patient had lost a large quantity of blood, and certainly was in a cachectic condition, and probably the tendency of blood to coagulate was thus rendered greater a clot, probably formed in the heart, and a small portion broke off and was carried to the brain, or perhaps there was a coagulation formed in some of the vessels of the brain itself, either in the arteries or veins.

Dr. Nish† relates a case of plugging of the superior longitudinal sinus and cerebral veins in a girl who had right-sided hemiplegia with aphasia. This, of course, is a very rare case.

Dr. T onge‡ says, coagulation may possibly be due to the presence of some morbid matter absorbed into the blood from the uterus, or that from some other cause the blood is in a state prone to coagulate."

Cases of puerperal cerebral embolism, judging from the scanty number reported are evidently rare. Embolism of the extremities and pulmonary artery is much more common, and Dr. Barnes§ gives two tables of embolism after pregnancy. The first comprising 15 cases of embolism of arteries and extremities. There were only two recoveries. Eight had early vegetations in valves in post mortem. Five had a history of acute rheumatism, and in the others, the heart was perfectly healthy. His second table comprises fourteen cases of pulmonary embolism after pregnancy, with death in all, of course. At that time Dr. Barnes had heard of no cases of puerperal, cerebral embolism, though he says it is quite possible they may occur either in the form of a simple clot, or minute particles may penetrate the finest cere-

\* Pathological Society's Transactions, vol. x.

† Transactions of the Pathological Society, vol. vi.

‡ Transactions of Pathological Society, vol. x, p. 117.

§ Transactions of Pathological Society, ol. xvi.

bral arteries or capillaries." In this way a clot formed in the right heart might break up, and minute particles carried through the capillaries of the lungs and eventually lodge in the capillaries of the brain, the capillaries of the brain, as is well known, being of very minute size.

If in these cases of embolism there is no heart disease, no history of chorea or rheumatism, and no disease of the blood vessels it is probable that the blood was clotted in the cavities of the heart, and minute particles of this clot were carried into the circulation and blocked up one of the arteries of the brain, so the middle cerebral cases of second attack after recovery are reported. Sir James Simpson\* relates one in which the woman recovered from the first attack, bore two more children, and during her third pregnancy had a second attack and died. There was no clot forming in the branches of the middle cerebral, but the corpus striatum of left side contained a cavity. Sir James says that from the time that had elapsed between the hemiplegia and the heaviest attack, possibly the clot had been absorbed. These attacks of embolism may occur during pregnancy or after labour. The earliest cases was the 7th month† of pregnancy, and the latest seven weeks‡ after labour.

RETENTION OF THE PLACENTA.—Mr. DAVIES reports in the *British Medical Journal* that about sixteen years ago, Mrs. G. arrived in London, and was seized with pains and threatened premature birth in six months. I ordered perfect rest, etc., and matters went on comfortably for a few days, when the foetus was expelled. The funis was torn off short at the os, which was rigidly contracted; and I determined not to interfere. During the whole time of retention, I was kept in constant anxiety, as periodical flooding came on; and on one occasion, I took the late Dr. Cape of Curzon Street, Mayfair, with me in consultation. After examination we agreed nothing could be done, but wait patiently. On the nineteenth day the placenta was expelled in a perfectly healthy condition without a sign of putrefaction.

\* "Edinburgh Medical Journal," vol. vii.

† Loc. Cit. p. 1085.

‡ Obstetrical Society's Transactions, vol. iv.

## Hospital Reports.

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

*Case of Encephaloid Cancer of the Axillary Glands, with secondary deposits in all the internal organs.*—Under the care of Dr. FENWICK. Reported by JAMES BELL, M.D., Assistant House Surgeon, Montreal General Hospital.

P. B., æt. 43, a large, well-built muscular countryman, of French-Canadian descent, was brought to the Hospital on the 11th of April, 1878. He was in great pain, and stated that he had some sort of a tumour in his right axilla. He was admitted to Dr. Fenwick's wards, but being very ill and suffering a great deal of pain, his history was obtained with difficulty, and is therefore incomplete. None of his family had ever suffered from cancerous disease. He had been a hard drinker, and during the greater part of his life had been engaged in laborious occupations. He was for four years employed in copper mines, and exposed to great hardships. He was then an axe-grinder for five years, in which employment his right arm was constantly wet. During the last eighteen months has been an hotel-keeper. Ten years ago he had a severe attack of acute rheumatism. Three years ago he first noticed severe, shooting pains in the right arm and elbow, and partial paralysis of the arm, but no swelling in any part. About ten months later he regained the use of his arm. He had then no pain nor trouble of any kind in the arm until Oct. 1877, when he was again seized with pain and partial paralysis of the same nature as the previous attack. There was now also pain on pressure along the spines of the lower cervical vertebræ, about the acromion process, and along the axillary border of the scapula, and also in the right infra-clavicular region. The pain was not increased by movement of the arm, and there was no swelling nor visible tumour. It was thought to be a rheumatic affection, and he was treated with iodide of potash, colchicum, and hypodermic injections of morphia to relieve the pain. In the beginning of February, 1878, he noticed a small swelling in the infra-clavicular

region, which he thought was caused by the puncture of the hypodermic needle. It was very tender and increased rapidly in size extending outwards towards the axilla, and upwards over the shoulder. The arm at this time began to swell, and soon became double its natural size. He weighed at this time 207 lbs. All these symptoms increased rapidly. He lost appetite and became thin and weak. He was obliged to take to his bed and to take increasingly larger quantities of morphia to relieve the pain. When admitted on the 11th of April, he weighed about 160 or 170 lbs, (having lost about 30 lbs. within three months), had a sallow and cachectic appearance and was very weak. A large, firm, lobulated tumour was felt in the right infra-clavicular region, extending from the costal cartilages into the axilla, and up on to the shoulder. The right arm and hand were double the size of the left, and had a tense, brawny feel. The liver was much enlarged, and very tender extending three inches below the ensiform cartilage in the median line, and from the upper margin of the sixth rib to the level of the umbilicus in the nipple line. No systematic examination of the heart and lungs was made on account of his great prostration, and as there were no special symptoms referable to them. There was œdema of the whole right side from the shoulder to the crest of the ilium. His left upper eye-lid was paralysed, and his left pupil dilated. Dr. Buller examined his eyes, and found that all the ocular muscles of the left eye were paralysed, but that the optic nerve and retina were perfectly healthy. He stated as his opinion that the interference with the functions of the 3rd, 4th, and 6th nerves, was probably due to pressure on those nerves just before their entrance to the orbit by the sphenoidal fissure. A consultation was called on the 13th, and Dr. Fenwick's diagnosis (malignant disease) was confirmed, as also his opinion that no operation could afford any relief, and that the disease must very soon terminate fatally. He became gradually and rapidly weaker, and died on the evening of the 15th. His intellect remained clear throughout, and no new symptoms were developed.

The autopsy was made by Dr. Osler, eighteen hours after

death, and the following notes have been transcribed from the post-mortem book.

*Body.*—Medium sized, well-formed and well nourished. Right arm and hand much swollen and œdematous, pale in colour, and double the size of the limb on the left side. In the right axillary region, and involving the shoulder is a large tumour surrounding the tissues in the neighbourhood of the head of the humerus. The largest mass fills up the axilla, being moulded upon the chest and convex externally. Above it reaches the clavicle, below the level of the seventh rib. Anteriorly it projects below the clavicle as a flattened tumour, extending to within  $2\frac{1}{2}$  inches of the sternum. Lower down it reaches the mammary line almost touching the nipple. Posteriorly it fills up the subscapular fossa, infiltrating and destroying the muscle in this region. The axillary vessels pass directly through the central part of the mass. A probe can be passed through the artery but its lumen is much narrowed. The vein pursues a sinuous course, and in places is almost obliterated by the projection into its lumen of nodular masses. It is not ulcerated at any spot. The cords of the brachial plexus are also compressed, but not infiltrated. The deltoid muscle where it passes over the head of the humerus is much thinned, while in its lower part it is infiltrated and in part destroyed. Immediately beneath the acromion process, and to the outer and back part of the head of humerus, is a large rounded projection which elevates and involves the terminal portions of the infra-spinatus and teres minor muscles. The coracoid process, and the tissues immediately in front of it form a large projecting mass which involves the fibres of the pectoralis minor. The scapula in the neighbourhood of the glenoid cavity is eroded, the articular surface being loose and almost separated from the body of the bone. The coracoid process and upper border of the bone are involved, the new growth passing through the bone and infiltrating the supra-spinatus muscle. The articular surface itself is not affected. The articular surface of the humerus is surrounded by cancerous tissue, presenting a peculiarly dry leathery appearance. It is non-vascular and not unlike the old fibrous laminæ of an aneurism. The ligaments are all

involved and the bone slightly eroded at the margin of the articular surface which is itself intact. On sections the large mass beneath the pectoral muscles, and in the axilla it is seen to be made up of a tolerably firm, and highly vascular structure. In the parts in the axilla an indistinct lobular arrangement can be seen. The surface of the section is greyish-white, and interspersed with blood-red areas of either congestion or extravasation. In the deeper parts it is drier and not so vascular. On opening the abdomen the liver is seen to project four inches below the costal border, and appears enlarged.

The *omentum* is small, and presents several small firm, reddish nodules. On inspecting the intestines and mesentery, a firm mass the size of an orange is seen to occupy the latter organ. Scattered over the mesentery, chiefly at its intestinal margin, are small nodular masses ranging in size from a pea to a marble. The peritoneal cavity contains 4 oz. of turbid, reddish fluid, but no lymph nor any signs of inflammation. The attachment of the diaphragm corresponds on the left side with the fourth rib on the right side with the third.

On opening the thorax one or two small firm nodules are found in the anterior mediastinum. The *pericardial* sac contains  $2\frac{1}{2}$  oz. of bloody serum. The right auricle of the heart contains a thick and gelatinous clot, which is continuous through the auriculo-ventricular opening to the ventricle, and so up the pulmonary artery, where it is colourless. The left auricle also contains a partially decolourized clot. Nothing abnormal in the orifices or valves of the organ. In the anterior wall of the left ventricle, towards its left border, is a cancerous nodule the size of a cherry, involving the muscular substance. Scattered throughout both lungs are numerous firm nodules, ranging in size from small marbles to a pigeon's egg. At the root of the left lung is a very large nodule, which appears continuous with the cancerous bronchial glands in the neighborhood. These bodies are very large, especially those just below the bifurcation. The pleural surfaces are covered over with innumerable small, opaque, fibroid masses, elevated chiefly upon pyramidal areas, and at the junction of the septa they are firm and nodular.



The lung substance presents scattered areas of dark, brownish-red pigmentation. The lungs are but slightly crepitant.

*The spleen* weighs 320 grms. It is large and of normal shape. Four large masses, white in colour, project from the convex surface and anterior border. The smallest one of them is cupped. On section these masses present sharp outlines, are of a reddish white colour, and here and there hæmorrhagic. Spleen pulp very soft.

*Kidneys*.—The right weighs 250, the left 270 grammes. Numerous nodules are apparent on the surface of both, varying in size from a pea to a marble. Some of these nodules are opaque-white, others dark red, or even black. Both organs are lobulated. The capsules detach easily except when the nodules are situated. On section the substance is interspersed with masses of cancer, chiefly in the cortices. In other parts the substance looks normal.

*Urethra and Bladder* normal.

*Supra-renal bodies* enlarged, each weighing about 50 grms.

*Pancreas* presents several secondary masses the size of marbles.

*The Liver* weighs 3970 grms. being uniformly enlarged. The surface is smooth, or presenting trifling inequalities in the form of roughened projections. No nodular masses are apparent. On section there is seen to be diffuse cancerous infiltration of extensive areas, not sharply defined, but blending insensibly with normal looking tissue. Indeed in places in the cancerous areas the outlines of liver lobules can be distinctly seen. Hardly a portion of the liver substance the size of a half-dollar, but does not show signs of the affection. The Gall-bladder contains a small amount of bile. The ductus communis choledochus is patent. No enlargement of glands in this neighborhood.

*Stomach* contains a quantity of milky fluid, and in the mucous membrane near the fundus is an elevated mass beginning to ulcerate on the surface. On section it is white in colour, and appears to be cancerous.

*Intestines*—From 15 to 20 small ulcers are seen throughout

the jejunum and ilium, 8 or ten being in the upper part of the jejunum. They range in size from a three-penny bit to a six-pence, or a little larger. The edges are much elevated, their bases cupped and covered with greyish-yellow material, beneath which is a firm, translucent matrix, involving the coats of the bowels to the depth of a line and a half. In the cæcum are a dozen or more ulcers presenting the same characters.

*Brain.*—Nothing abnormal in the membranes, and a careful dissection reveals nothing abnormal in the brain substance itself. The sella turcica is occupied by the pituitary body, which appears large and soft and extends as a firm mass into the left cavernous sinus, surrounding all the textures in that situation.

On examination this is found to be cancerous infiltration involving the pituitary body and the tissues in the cavernous sinus of the left side, converting them into a firm, immovable mass. The third nerve runs along the top of the mass, and can be dissected from it without much trouble, but is compressed by it. The fourth nerve is imbedded in the upper part of the mass. The fifth nerve passes to the outside and does not appear to be involved. The sixth is on the under surface, and in part of its extent is surrounded by the cancerous growth. The artery does not appear to be at all compressed.

*A Case of Dislocation of the Femur on to the Dorsum of the Ilium.*—Under the care of Dr. REDDY. Reported by JAMES BELL, M.D., Assistant House Surgeon Montreal General Hospital.

J. E., a large and powerfully-built Englishman, was admitted to the Montreal General Hospital on the 14th of April, 1878, with a recent dislocation of his hip-joint. He was an unmarried man, a laborer, 52 years of age, but looking much younger. On subsequent investigation we discovered no family history of constitutional disease. He had always been healthy with the exception of a mild attack of typhoid fever some years ago. He had always been engaged in hard work, and had been a pretty hard drinker. All his organs were healthy. He was

carried in on a stretcher about four o'clock in the afternoon, suffering very great pain, and gave the following account of the accident. About six hours prior to being brought to the Hospital he was wrestling with another man, and was brought to his knees, when he put his head between his antagonist's legs, and attempted to rise with him on his shoulders. He felt himself falling towards the left side, and on endeavoring to regain his equilibrium he fell and heard something give way in his hip, and he fell over on that side. He found that he could not straighten out his leg, and the pain was very intense. When undressed and put to bed there was no difficulty in diagnosing dislocation of the femur on to the dorsum of the ilium. There was immobility of the joint, the thigh was half flexed on the abdomen, the knee rested on the opposite thigh, about two or three inches above the knee, the whole joint was inverted and shortened by about two inches, and the ball of the great toe rested on the instep of the opposite foot. On drawing *Bryant's triangle*, the base line was found to be an inch and a quarter shorter on that side, and finally the head of the bone was readily felt on the dorsum of the ilium. Dr. Reddy, into whose ward the patient was admitted, was at once sent for, and on his arrival the patient was carried to the operating-room and put thoroughly under the influence of chloroform. Dr. Reddy then proceeded to reduce it by rotation, and succeeded in doing so on the first attempt. The legs were then bound together and he was carried to his bed, and an ice bag applied to the joint. He suffered very little pain after the reduction of the dislocation, but for several days there was a good deal of effusion into the joint. The ice-bag was kept constantly applied for about a week, and then the hip was painted with the tincture of iodine. After remaining two weeks in bed he was allowed to get up and move about, and was finally discharged on the 4th of May, quite well, with the exception of a little stiffness in the joint.

## Reviews and Notices of Books.

*A Compend of Diagnosis in Pathological Anatomy, with Directions for making Post-mortem Examinations.*—By DR. JOHANNES ORTH. Translated by T. C. SHATTUCK, M.D., and G. K. SABINE, M.D., revised by REGINALD H. FITZ, M.D., with numerous additions from M.S., prepared by the author. 8 vo. n. xxxi. & pp. 440. New York: HURD & HOUGHTON, 1873.

With the exception of a short translation of a manual by Virchow, quite recently published on “*Post-mortem Examinations, with especial reference to the Medico-legal practice,*” no work in the English language has appeared as a guide to the student in the post-mortem room. This, probably, is due to the fact that no special systematic work can be accomplished. The student is forced to take advantage of what comes before him. There is a great difference between the method of study in the dissecting and in the post-mortem rooms, and in the latter the student is left very much to make out for himself what he sees as a result from diseased action, and to interpret its meaning. In saying this we do not wish to infer that pathological anatomy has been neglected, and that no works exist on that subject, nevertheless, we are forced to admit that very few such books as the one before us has appeared in the English language, and that the student is left to make out the conditions observed, without the aid of a guide-book. The work done in the post-mortem room, is desultory and inconstant, no regular order can be followed, so that to be of benefit the student has himself to place the knowledge there gained in some order of arrangement in his subsequent reading.

In the preface to this work the author very correctly observes that “*absolutely practical knowledge can only be fully obtained from actual experience in performing autopsies;*” and he also remarks that “*in order to make this experience the more profitable, it is necessary that a theoretical knowledge should first*

be acquired, not only of the course and method, of the examination, but also of the alterations which may take place in the several parts, and their characteristic peculiarities."

In making a post-mortem examination of a body the student may simply desire to confirm a diagnosis, or to ascertain the condition of one or other of the organs or parts involved in disease, for this purpose the organs may be removed from the body and so examined. If, on the other hand, he desires to obtain a clear insight into what has been brought about by disease in the different organs, of latent morbid changes, a thorough and methodical examination is essential. If the actual cause of death is sought for, each and every organ individually and in its association with other organs must be examined, otherwise some important point may be overlooked. Again, in medico-legal investigations, the examiner should not confine his researches to those changes immediately connected with the legal questions at issue, otherwise he will be himself deceived, and from the imperfect investigation, he will not be in a position to give a decided and weighty opinion.

After a few general introductory remarks chiefly alluding to the preparation of the body for examination, the instruments and chemical reagents, necessary, the author passes on to the inspection of the body, and he shows how necessary it is to take note of all circumstances observable, as well as the time when death occurred, and the manner of it; the general attributes of the body, age, sex, stature; whether well nourished or emaciated; signs of death and decomposition; all marks or injuries, whether bruises, wounds, discolorations, and the amount of cadaveric rigidity. These circumstances should first be noticed, and a record made of them before the internal examination is proceeded with. Specific directions are then given how to proceed, and what to examine, as well as what may possibly be found in all the organs and tissues of the body. This is a most valuable and useful work, and should be in the hands of every practitioner, because at any time he may be called upon to inspect a body where death has come under suspicious circumstances. We recommend it to all our readers.

*The Source of Muscular Power, Arguments and Conclusions, &c.* By AUSTIN FLINT, JR., M.D., Professor of Physiology, &c., Bellevue Hospital Medical College. 12 mo., pp. 103. New York: D. APPLETON & COMPANY, 549 & 551, Broadway, 1878. Montreal: DAWSON BROS., St. James Street.

This little book is a reprint from an article which, was first published in the October (1877) number of the *Journal of Anatomy and Physiology*. By some ill-luck, the author did not receive the proof sheets before publication, and he remarks in his preface that, as the paper originally appeared "the typographical errors, both in the figures and in the text, were quite important," hence, he was in a measure obliged to issue this book from the press so as to present an accurate statement of his own observations, and what seemed to him to be "the logical conclusions to be drawn from these as well as from experiments made by others upon the human subject under the conditions of rest and of muscular exercise. From the publication of the experiments of Fisk and Wislicenus in 1866, and of others of more recent date, a theory had been propounded that the muscular system of man and other animals is simply a perfected mechanical apparatus, which performs work not at the expense of its own substance, the material consumed, being restored by the assimilation of food, but by the consumption of food itself, and that the force value of the food so ingested, can be calculated much in the same way as can be estimated the value of the fuel consumed by a steam engine.

This certainly would be an important addition to positive knowledge if the theory could be substantiated, but it appears, although plausible, to be contrary to known facts. Take for instance any muscle or group of muscles, and exercise them continuously, the work will not only be done, force will not only be evolved, but the muscle itself will increase in size and development, and an increased number of muscular bundles will be produced. No amount of fuel to the steam-engine will add to its store of iron, or increase its power of resistance, so that the two processes although of the same genus are separate and

distinct. This little work is highly interesting and instructive, as it contains a series of tables made by the author and Dr. Pavy of London, as a result of experiments carried out by those gentlemen upon Weston, during his pedestrian feats both on this continent and in England. It contains much information on physical training which will be sought after by the reading public. It is to be had of Dawson Brothers, St. James Street.

*Hand-book of the Practice of Medicine.*—By M. CHARTERIS, M.D., Professor of the Practice of Medicine, Anderson's College, Glasgow, with illustrations. 8 vo. pp. 336. Philadelphia: LINDSAY & BLAKISTON, 1878. DAWSON BROS., St. James Street, Montreal.

This little work is published by the author for the purpose of recording the experience which he has gained as a physician and lecturer on clinical medicine at the Glasgow Royal Infirmary. The arrangement of the subject is similar in many respects to the generality of works on Practice of Medicine. He commences by a few general observations on disease and with bed-side hints. These are accompanied by three outline wood cuts indicating the various regions, both on the anterior and posterior surfaces of the trunk, and in a familiar way the author recommends the student to accustom himself to the different sounds elicited by percussion and auscultation in healthy individuals, so that he may more readily distinguish any departure from a healthy standard. He then passes on to the discussion of diseases proper, commencing with fevers, after which he takes up severally diseases of the respiratory organs; the organs of circulation; diseases of the abdominal viscera; of the nervous system, diseases of the spinal cord, diseases of the skin, and lastly parasites. The appendix is devoted to a series of prescriptions, which, we suppose, the author is in the habit of ordering. There are under the several headings of alteratives, resolvents, antacids, antispasmodics, diaphoretics, diuretics, emetics, expectorants, gargles and inhalations, lotions, liniments, salines, sedatives, stimulants, tonics, &c. These are all good in their way, and will be found of use. It is, what it proposes to be, a short, concise hand-book, and very good of its kind.

## Extracts from British and Foreign Journals.

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

### **Ovariectomy in a child of twelve years.**

DR. T. BARLOW read notes of this case, which had been under the care of himself and Mr. Howard Marsh at the Children's Hospital, Great Ormond-street. The enlargement was on the right side of the child's abdomen, and consisted on the extreme right of a hard mass, internal to which, and attached to it, was a tight cyst. The whole tumour was slightly movable and painless, and had been eighteen months growing. The child had scarcely any symptoms; she suffered only from a little constipation. Her temperature was normal. Chloroform having been given, a hypodermic syringe was introduced into the cyst two inches below the umbilicus, and one drachm of clear straw-coloured fluid was withdrawn. Next day the temperature had risen to  $94.4^{\circ}$ . Four days subsequently the tumour was considerably collapsed, the abdominal surface was flattened, and the hard part of the tumour was now quite definite. It evidently contained some material as hard as bone. The cyst had become quite soft and flabby, and gave no evidence of fluid. After about six days the cyst refilled. Fifteen days subsequently it was completely aspirated, and six pints of fluid were removed. The cyst, however, again filled. Ovariectomy was then performed by Mr. Marsh. There were no adhesions between the tumour and its surrounding parts. When it had been thoroughly exposed by the incision into the abdomen, it was tapped, and eighty ounces of light brownish-green fluid were drawn off. The remaining solid portion of tumour was still too large to be drawn through the opening, which was three inches long; it was consequently extended nearly to the pubes. The thick and fleshy pedicle was clamped by Mr. Spencer Wells's method and divided. Bleeding points in the omentum were secured by catgut; and the wound was closed with sutures. No subsequent bad symptom occurred. Pain in the abdomen was treated with morphia suppositories. After the eighth day several sutures were removed; the bowels acted spontaneously on the twelfth



day; and the clamp dropped off the pedicle on the thirteenth day. For some weeks the stump of the pedicle remained protruded and covered with florid granulations. It at length became completely retracted, and the child was discharged well about eleven weeks after the operation. The tumour weighed two pounds eleven ounces; it measured six inches across, and seven inches from above down, and was nearly spherical in shape. The lower half was composed of a thin-walled cyst, capable of holding a large cocoa-nut; it had projected into its cavity several smaller cysts. The hard part contained a plate of bone measuring two inches by four inches, and other smaller pieces of bone. There were cysts at the upper and outer part of the growth, with gelatinous and solid contents, many of which contained sebaceous matter, with collections of dark short hairs. There were also fibroid bands and irregular spiculæ of bone interposed between some of the cysts:—*Medical Times and Gazette.*

**Strangulated Femoral Hernia.**—(Operation for Strangulated Femoral Hernia, in which an Anomalous Obturator Artery was divided.)—Mr. BARKER read notes of this case. The patient, a woman of fifty-six, was operated on in the usual way on February 7. Most of the constricting fibres were easily divided; but on severing some which remained, embracing the neck closely, blood welled out of the wound. The latter was enlarged and the vessel sought. As it could not be found and the bleeding soon ceased to be severe, it was deemed advisable to apply pads over the wound and compress with bandages. On the 8th the patient was better, and on the 9th better still. Early on the morning of the 10th, however, she took a turn for the worse (indicating peritonitis), and died at 5 p.m., on the same day. A post-mortem examination revealed acute peritonitis with serous effusion. Near the wound, about three or four inches of blood were found effused underneath the peritoneum in the pelvis, above and at the right side of the bladder. This blood came from an anomalous obturator artery passing down on the inside of the neck of the sac. It sprang from the epigastric, about half an inch from its origin, and was

completely severed at about three-fifths of an inch from its commencement. Its vein lay to the outside of the sac. The proximal end was plugged; the distal had furnished the bleeding. Mr. Barker remarked that his object in bringing the case before the Society was not only that it was a rare one, but that he hoped to elicit an expression of opinion from the members as to the best mode of dealing with cases where this rare accident had occurred. Was the artery to be sought at all costs, and ligatured: or was it, in certain cases, as in this, to be left to itself, controlled by pads? He had with a good deal of trouble and search through English and foreign literature, succeeded in collecting only twelve cases where this accident had occurred, excluding doubtful cases where no correct record had been given. Out of these, he said, it was remarkable that in six the vessels was secured with ligature or hook, and in six it was left to itself. Of the first six, two died; and of the second six, one (the present case) died of peritonitis. Without desiring to make too much of these facts, he thought that the one line of practice was at all events justified as well as the other, although in some books very positive statements were made as to the urgent necessity of seeking the artery and placing a ligature upon it.—*Medical Times and Gazette*.

**The connection between Pruritus Vulvæ and Diabetes.**—Dr. Wiltshire calls attention to the frequency with which pruritus vulvæ is associated with diabetes, and points out the desirability of a systematic examination for sugar in suspicious cases. He remarks that apart from the itching there may be no symptom whatever of diabetes—polyuria, loss of flesh, nor large appetite; and it is not, therefore a matter of surprise that the underlying diabetic affection frequently remains unsuspected. He records a case of a stout, florid, middle-aged woman, who came under his care tormented with violent itching of the vulvæ. Suspecting diabetes he had the urine examined, and then and ever since, it has contained sugar. The treatment which proved perfectly successful, consisted merely in the application of a borax lotion.—(*Lancet*, April 13, 1878.)—*Practitioner*, May, 1878.

**Treatment of Epulis by Electrolysis.—**

At a late meeting of the Clinical Society Mr. Nunn, read some notes of cases of epulis treated by electrolysis. He remarked that this mode of treatment was peculiarly applicable to such cases, as the present difficulties to ordinary operative proceedings, and the hæmorrhage that follows is often considerable. The first case was that of a lady, in whom a sensitive and vascular growth, the size of half a walnut, prevented the adaptation of artificial teeth. The patient declining any operation by the knife, the electrolytic treatment was carried out. There were about twenty sittings; six or three cells were used. The tendency to bleed diminished with the progress of the treatment. The pain caused by the current was in proportion to the number of cells employed; it was unbearable when bone or peritoneum were touched by the needles, and it ceased immediately on their withdrawal. An injection of chloride of zinc produced intense pain and subsequent irritation. The patient was enabled to wear artificial teeth after the treatment. Mr. Nunn reported three other cases. He advocates electrolysis in these cases mainly on the grounds of its painlessness, ready applicability, and freedom from hæmorrhage. The cells employed contained manganous oxide and iron, chloride of ammonium being the exciting fluid. The electrodes should be of gilded steel, or of platinum.—(*Lancet*, April 20, 1878)—*Practitioner*.

**New Mode of Treating Varicocele.—**

Mr. S. [Messenger Bradley states that he finds the following simple procedure an efficient method of treating varicocele. Pass a long and strong hare-lip pin between the veins and scrotal walls, bringing the point of the pin close beneath, but not through the scrotum; then make the point retrace its course, but passing now behind the veins until it emerges near the puncture through which it entered. In a word, by applying that form of acupressure, known in the Aberdeen School as the method of retroclusion.—*British Medical Journal*. March 16th, 1878.—*Practitioner*.

**Morphia in cases of Aneurism.**—(Morphia and a tell-tale as aids to compression in aneurism. By C. F. MAUNDER, F.R.C.S., Surgeon to the London Hospital.)—In my Lettsomian Lectures of 1875, I drew attention to the value of Morphia as an aid to compression, as a substitute for chloroform and its attendant risks. I illustrated its use in the case of a gentleman who “dozed, took his meals, smoked his pipe, and submitted to continuous digital compression for twenty-three hours, with scarcely a complaint; and at the expiration of this time, expressed himself as capable of enduring treatment many hours longer.” The following is another example of the value of the drug.

In February 1877, Mr. —, who is now forty-two years of age, was advised that he was the subject of an aneurism of the popliteal artery. He was put to bed and treated for the first ten days with a bag of shot weighing eight pounds placed over the common femoral artery. During the next month a tourniquet was substituted, and worn during eighteen hours out of the twenty-four over the superficial femoral artery. His health now began to fail; treatment was discontinued; and he went to his business, the tumour being smaller, and pulsation less marked. During the last three months, the swelling and the pulsation had both increased, associated with pain and general discomfort about the knee.

March 29th. 1878, I found Mr. — with an aneurism of the size of a large orange occupying the upper half of the popliteal region, and bulging somewhat to the inner side of it. Continuous digital compression with a weight of ten pounds was advised, aided by morphia, if necessary.

March 30th. Mr. W. R. T. Hawkins and Mr. Albert E. Jones of the London Hospital commenced the compression treatment at 11.45, A.M., the common femoral being the artery selected; and they maintained complete occlusion of this vessel for the space of half an hour alternately. At 4 P.M., the patient suddenly complained of severe pain (distal occlusion?), commencing in the calf of the leg, and running up along the aneurism and femoral artery. A quarter of a grain of morphia was now hypo-

dermically injected, and relief afforded. From this time, when the gentleman compressing was relieved by his colleague, and the pressure for the moment somewhat relaxed, the force of the pulsation in the aneurism was observed to be gradually diminishing. At 8 P.M., an assistant was recruited, in order to help in the continuation of the compression through the night.

March 31st. At 2 P.M., another paroxysm of pain occurred, after which pulsation was scarcely, if at all, perceptible; and a firm swelling occupied the seat of the aneurism, the disease being practically cured. At 10. A.M., no pulsation could either be felt or seen. One of the arteries could be detected meandering the knee. Compression was the whole time (thirty hours), the patient lay on his back, with the thigh rotated outwards, and the leg flexed at a right angle on this. An indicator which consisted of a penholder with a piece of paper like a flag placed between the nibs, and which marked the presence or absence of pulsation in the aneurism) was lodged like a finger post in the flexure of the knee, and acted like a tell-tale to the compressor. M.— took food at intervals, and was cheerful and chatty, except when asleep. An injection of morphia was resorted to four times. The skin over the seat of compression which had been protected by the occasional application of French chalk, was slightly reddened only, and was the source of the least possible discomfort to the patient, who said he could have borne the treatment many hours longer.—*British Medical Journal*.

### **Remedy against respiratory Obstruction.**

—(An anatomical remedy against respiratory obstruction from the tongue, epiglottis and vellum palati in threatened apnœ from anæsthetics or other causes.)—Dr. BENJAMIN HOWARD remarked that the object of the paper was to give the results of various and repeated investigations and experiments. The facts to be presented confirmed the alleged respiratory obstruction from the tongue, epiglottis, and velum palati in apparent death in the ordinary supine position, and showed how much obstruction was promoted by the customary elevation and flexion of the head and neck. Traction upon the tongue, how-

ever firm, might open the pharynx, which its retreat had closed, but nothing more; the epiglottis remained unlifted. Other facts were then presented, proving how, by simple position, all these obstructions were instantly removed. The position consisted in the elevation of the thorax and complete extension backwards of the head and neck. By this means, the line of gravitation of the tongue was shifted from the back of the pharynx to the hard palate at or about its junction with the soft palate. The entire posterior wall of the pharynx was shifted backward; its anterior wall was shifted forward; thus, its antero-posterior diameter, as much as possible, was throughout increased; while, by the shifting upward of the nares their entrance was brought more directly over and in a line with the course of the pharynx. The larynx being pulled downward and upward and backward of the lower jaws upon the stretch the *genio-hyoid'i*, *mylo-hyoidei*, anterior bellies of the *diaphragmatic* muscles, causing the hyoid bone, and by means of the *hyo-epiglottic* ligament, the epiglottis, to share together the motion of the jaw. Thus the epiglottis was instantly made vertical. The thyroid insertion of the *palato-pharyngei* muscles being brought downward and forward by the *sterno-thyroidei* and fixed, The *palato-pharyngei* muscles were put upon the stretch, their whole length by their extensive movement upward and backward of the head; and thus the posterior pillar of the fauces, the arches of the palate, and the *velum palati*, into which latter membrane these muscles were inserted, were all pulled downward and forward; they were thus made tense and kept so. The *velum* being thus stretched some distance in front of the back of the pharynx, a post-oral airway was secured, from which the tongue was doubly excluded. Hitherto in the treatment of apnoea and asphyxia, the tongue had been withdrawn, only in those exceptional cases where a surgeon with forceps had been present. The means of complete elevation of the epiglottis in cases of apnoea had been hitherto unknown. The position described removed both those obstructions without assistant or instrument. The author from the facts given and from other experiences, urged that always in the induction and condition of

anæsthesia the head should rest rather lower than the shoulders. He also stated that complete extension backward of the head and neck should be the first and instant measure in threatened or actual apnœa, both as a remedy and as the first step towards success by artificial respiration. The withdrawal of the tongue when practicable, the author considered highly advantageous, though not necessary; but it should incur as little lowering of the inferior maxilla as convenient. Finally, the author claimed to have demonstrated that, contrary to the general belief, traction upon the tongue, however firm, cannot materially elevate the epiglottis; that he had discovered a simple way by which (1) the tongue is excluded from the pharynx without manipulation; (2) the epiglottis is elevated vertically at will; (3) an inobstructed post-oral airway is secured from the glottis to the nares—all of which is effected simultaneously by position alone. These facts had received corroboration from recent observations upon anæsthetized patients; and the author was glad to believe that, in averting apnœa, in restoring from apnœa, and enabling various means of artificial respiration to be used more effectively, the simple position above directed will be a frequent means of saving human life.—*British Med. Journal.*

### **Subcutaneous Injection of Chloroform in Neuralgia.**

—E. Besnier gives the results of his experiments on the effects of the hypodermic injection of chloroform. In one case of sciatica where many other means had been used without success, and where the injections of morphia had been requested to be discontinued by the patient himself on account of the distressing after effects, the injection of from ten to fifteen drops of chloroform gave immediate relief to the pain, which lasted for several hours. In other cases he has injected as much as twenty drops with equal success. He observes, however, that the injection requires to be practiced with some care, and the fluid should only be allowed to penetrate the subcutaneous connective tissue in order that painful effects may be avoided.—*Bulletin Général de Thérapeutique*, B. xciii., 1777. No. 10.)—*Practitioner.*

**Topical use of Iodoform for Otitis Media Catarrhalis.**—Dr. M. J. De Rossett, of Wilmington N.C., calls attention to the topical use of iodoform in catarrhal inflammation of the tympanum and Eustachian tube, particularly where there is perforation or loss of the tympanic membrane. In many instances its effect has been little short of marvellous, and in all well-marked. Even a case of nineteen years standing was speedily cured as to the discharges, and greatly benefited as to audition. The ears are cleansed in the usual way with a stream of tepid water, and dried with pledgets of cotton. Iodoform is then introduced by a Ranchfuss tube or by means of a cotton mop on a staff in sufficient quantities to cover thickly the entire tympanum. Repeat this two or three times a week, always cleansing in advance. The *modus operandi* is obvious. Iodoform is a disinfectant; a dessicant which prevents the diapedesis of white corpuscles, and promotes the activity of the absorbent vessels.—(*Maryland Medical Journal*, September, 1877.)—*Practitioner*.

**A Unique Case.**—Dr. Donald Maclean, Professor of Surgery in the University of Michigan, reports the following unusual case in the *Michigan Medical News* for April 25th, 1878. The patient was a child of three years who was suffering from a painful swelling of the right upper jaw, supposed to be abscess of the antrum.

On examination I found the face much swollen on the affected side, the lachrymal duct seriously obstructed, and the skin irritated somewhat by the flow of tears. On looking into the mouth, which was done under chloroform, pus was observed exuding from the middle of the alveolar process in the right side. The introduction of a small probe into this little sinus at once revealed the presence of a minute scale-like exfoliation, which was easily removed by means of a small dissecting forceps. This done, I at first supposed that there was nothing more to do, and as the parents were extremely nervous about the anæsthetic I was not unwilling to believe that the time had come to permit a restoration to consciousness, and so relieve their apprehensions.



A moment's reflection, however, induced me to suspect that the exfoliation which had just been removed, was insufficient to account for all the conditions present, and I therefore insisted upon a more prolonged exploration. On passing the probe into the opening in the alveolar margin, it at length appeared to touch something in the antrum, which appeared to be unattached. Accordingly I used a pair of pointed dressing forceps to increase the calibre and the little sinuous channel in the alveola, and then I had no difficulty in seizing, and by the exercise of some force withdrawing *the perfectly developed crown of a perfect molar tooth*, with a little mass of glandular structure, which reposed in the concave surface from which the fang should naturally have projected.

No other treatment was advised, and some months afterwards I saw the little patient in good health and much improved as regards the facial deformity.

The specimens derived from this case are now in the possession of Prof. Taft of the Dental College University, by whom they were recently presented at the meeting of the State Dental Association, the members of which were unanimous in the opinion that the case is an unprecedented one.

**The Seton.**—In the recently-published report of the United States Marine Hospital Service will be found a paper by Dr. Griffiths on the "Seton in Paralysis and Epilepsy." Of eighteen cases of hemiplegia treated in the Marine Hospital, Louisville, in one case only, that of a patient who died under treatment two months after admission, did the seton fail to benefit. Of the other seventeen cases, ten recovered, and the rest were much relieved. Four out of the five cases of epilepsy treated with the seton were greatly benefited. The author introduces a large seton fifteen to twenty strands of silk or flax thread, and allows it to remain for months if necessary, removing it only when the patient is either permanently improved, or too great irritation is produced. Dr. Griffiths states that he has also used the seton with good results in the treatment of obstinate iritis.—(*Lancet*, March 16th, 1878.)—*Practitioner*.

### **Diffusion of Cancer along the Nerves.**

Dr. COLOMIATTI relates (*Rivista Clinica di Bologna* and *Lo Sperimentale*, March) a case which occurred in Dr. Spantigati's practice in the Hospital of St. John, in Turin, in support of his theory of the manner of diffusion of cancer.

The subject was a man, aged 40, who had apparently been always healthy, but in whom, after intense neuralgia in the part of the left cheek, corresponding to the lower teeth, a tumour grew from the inner side of the gum, at the seat of pain. The tumour, which increased rapidly, was diagnosed by Dr. Spantigati as cancerous, and was removed, along with the portion of the lower jaw extending from the left canine tooth to the temporo-maxillary articulation. Surgically the operation was successful, and the wound soon healed completely; but, after remaining some time in hospital, the patient was obliged to return to his home, still suffering severely from acute pain, which was only temporarily relieved by subcutaneous injections of morphia.

The tumour, with the bone removed, was presented to Dr. Colomiatti for examination. It was lobulated, and nearly as large as a hen's egg. It contained in its substance the dental nerve, which, however, could be followed for more than four-fifths of an inch before its entrance into the dental canal. Along with the tumour a suprahyoid gland was removed, as it was somewhat hard.

After a careful examination, Dr. Colomiatti was led to agree with Dr. Spantigati as to the carcinomatous character of the tumour. Its origin from the epithelial covering of the gum, at a point corresponding to the molars, explained, in his opinion, the dental neuralgia which preceded its appearance.

Dr. Colomiatti next turned his attention to the dental nerve, the posterior portion of which seemed to be more voluminous than normal. Sections of the portion comprised in the tumour presented remarkable changes, in explanation of which Dr. Colomiatti refers to the view held by Robin, Key and Retzius, etc., according to which two forms of connective tissue enter

into the formation of nerves—viz., the epineurium, and the perineurium with its appendage, the endoneurium.

The epineurium connects the funiculi, which form every nerve-trunk; the perineurium and endoneurium form an integral part of each funiculus. Their connective tissue consists of small membranous films, between which are the so-called perineural and endoneural lymph-spaces, which, however, have nothing to do with the common lymphatic system. These membranous films, the endoneural membranes, which proceed from the perineurium, surround the nerve-fibres. Each nerve-fibre is thus suspended in a lymph-space.

In the case now under consideration, Dr. Colomiatti states that he found, on making section of the dental nerve, an abundant cancerous infiltration, diffused along the perineural and endoneural spaces, the perineurium presenting solutions of continuity, due to the invasion of the epineurium by the cancer-cells.

Dr. Colomiatti says that this is the second case in which he has observed the diffusion of cancer in the inferior dental nerve. There is, however, a difference between the two cases. In the first (cancer of the lower lip), the disease was diffused by the lymphatic vessels belonging to the neighboring glands; while, in the present case, the gland which was removed, in consequence of being hard and probably cancerous, was found, on examination, to contain no cancer-cells, and the diffusion of the disease had taken place solely along the nerve. This supports the idea of Colomiatti, that the nerve may become diseased before the lymphatics, and independently of them; the lymphatics become infected later, and when they do, the disease proceeds more rapidly. In this case it was observed that the anterior portion of the nerve, which was examined, had no cancer-cells in its lymph-spaces; hence he infers that the diffusion took place centripetally.

The persistence of the severe pains, in spite of the complete removal of the tumour with the neighboring parts, is ascribed by Dr. Colomiatti to the diffusion of the disease along the nerves; and he advises that, before undertaking an operation in such cases, the state the nerve should be observed. —*London Medical Record.*

**Extraction of Steel and Iron from the Eye by the Magnet.**—The following cases, recorded by Dr. W. A. McKEOWN, Surgeon to the Ulster Eye, Ear, and Throat Hospital (*British Med. Journal*, May 4, 1878), will be of interest taken in conjunction with that recently brought before the Clinical Society of London by Mr. McHardy.

CASE I.—Dawson B., aged 24, smith's helper, applied to me at the Hospital on January 16, 1877. He stated that three days previously, his right eye had been wounded by a small piece of metal. I observed that the iris was attached to the lens at the outer part of the pupil by recent lymph, and that there was a small limited opacity of the lens. There was a small, clear, metallic body sticking at the margin of the adherent pupil. I made a small section of the cornea, more peripheral than the pupil, introduced a pair of iridectomy forceps, seized the body and a little piece of iris, but the body slipped from my grasp, and was sliding out of my reach. Fortunately, I anticipated such an untoward event, and took care to have a pointed permanent magnet at hand. I introduced it into the wound. The metal was instantly attracted and extracted. The patient continued under my observation till February 16. The opacity of the lens remained limited to the point wounded. I believe that the wound in the capsule was closed by lymph and healed. I have not seen or heard from the patient since.

CASE II.—Moses E., aged 32, millwright, consulted me at the Hospital on November 20, 1877. He stated that three-quarters of an hour before his visit, his right eye had been wounded by a chip of steel from a hammer. I observed a wound a little more than a line long in the ciliary region just at the corneo-sclerotic junction. One end of the wound penetrated the anterior chamber, as shown by the evacuation of the aqueous humour and a slight displacement of iris towards the wound. The wound was quite clean, and no foreign body was visible. The media were clear. The ophthalmoscope did not disclose the presence of any foreign body. I put the point of the magnet cautiously into the wound, and at once it proved the presence of metal within the sclerotic by the click and the attraction. By

a little patient and careful use of the magnet, the metal was brought into the wound, and the end of it exposed so far as to enable me to grasp it with forceps. Having caught it I easily extracted it. The fragment was a thin piece about one and a half lines long, one line in width at one end, and half a line at the other end. The patient recovered completely, and returned to work on December following.

There can hardly be a doubt that the magnet saved the eye in both cases. In the first case, to have followed the sharp fragment with forceps would probably have inflicted irreparable damage, and indeed the body might have got out of the way altogether. In the second case the metal would but for the magnet probably have remained undetected, and have afterwards lighted up destructive inflammation. Even had it been detected, it would not have been possible, but for the magnet, to extract it without enlarging the wound, and that is not desirable in any part of the eye, much less in the ciliary region. By the magnet the diagnosis was established, and the extraction was accomplished in the most delicate way.

### **Case of Gunshot Wound of the Brain.**

—Dr. Rossi relates in the *Annali Universali di Medicina e Chirurgia* for December, 1877, the case of a lad, aged 16 or 17, who, having bought a revolver, was one day amusing himself by shooting at a target with one of his friends. After discharging some shots, he recharged the weapon and drew the trigger, but it would not go off; he therefore looked down the tube, when the revolver exploded suddenly, the ball striking the upper part of the left eyelid, just outside the groove for the passage of the vessels and the supra-orbital nerve, fracturing the frontal bone, and entering the brain.

At first only the immediate local symptoms were observed but the next morning the right arm was painful and paretic, and there was an appearance of brain-substance at the orifice of the wound. In conjunction with Dr. Rouge, Dr. Rossi made an incision about an inch and a quarter upward, when the pulsations of the cerebral matter, isochronous with those of the heart,

were distinctly discerned, and there was found to be a radiated fracture of both tables of the frontal bone immediately above the orbital arch. Through this a probe could be easily introduced to the depth of five centimetres (two inches) in an oblique direction, from below upwards, and from before backwards, without coming into contact with the projectile. Ice was applied, and six leeches behind the left mastoid process.

Contrary to all expectation, the pain and paresis of the right arm soon disappeared; the cicatrization of the wound took place without necrosis, and almost without suppuration; and the patient was well in a few days.

The author, assuming it to be certain that the bullet entered the brain, asks in what part of that organ it could be lodged, there being no nervous disturbance, either paretic or paralytic. *London Medical Record.*

### **Syphilitic Interstitial Glossitis.**—

Dr. C. MAURIAC has published an account of this affection (*Le Progrès Medical*, 1877, No. 45), which is in character similar to syphilitic sarcocele, and consists of an inflammatory induration of the fibrous partitions separating the muscular fasciculi of the tongue. It begins always in the dorsal surface, at first being superficial, and then invading the deeper tissues. It is more frequently met with in men than in women. There appear to be a hypertrophic and an atrophic period. In the former the enlarged, hard, and painful tongue presents on the dorsal aspect hollow furrows filled with macerated epithelium. There are noticed large papillæ, and often ulcerations, at the points where the tongue touches the teeth, or in the bottom of the above-mentioned furrows. The second stage is that of retraction of the new tissues, and then there is a deep and antero-posterior fissure, with several irregular fissures. Finally as atrophy progresses, the organ becomes smooth and shining, is divided into little lobules, and gives the sensation of a tongue made of wood. Specific treatment is seemingly of some service in the early stages, but is entirely useless when the disease is advanced.—*London Med. Record.*

**Remedies in Epilepsy.**—Dr. ERLLENMEYER, in the *Correspondenz Blatt*, collects a number of testimonies, from different German physicians, to the benefits derived from the treatment of epilepsy in asylums and institutions for idiots.

Dr. Bertelsmann, physician to the Institution for Epileptics at Bielefeld, remarks, that though he does not believe bromide of potassium to be a specific agent against epilepsy, he is persuaded that it occasionally effects a cure. At the same time he quotes the opinion of Dr. Auguste Voisin, that though oxide of zinc acts more slowly than the bromide of potassium, its effects are more certain; and after having used both these medicines for more than twenty years he habitually gives the preference to the oxide of zinc, used after the method of Harpin, of Geneva. Dr. Erlenmeyer has tried bromide of lithium, which was recommended by Dr. Levi, of Paris, as more efficacious than the bromide of potassium, and as having no action upon the heart.

From his own experience he is disposed to believe that it is inferior to bromide of potassium as a remedy against epilepsy. He has also tried bromide of quinine, and found it had a more hypnotic action than bromide of potassium; he finds it useful in treating periodic fits of insanity and hypochondria, but is not inclined, on the whole, to give it the preference to the more commonly used drug.—*Medical and Surgical Reporter*.

**Bichromate of Potash in Syphilis.**—In the *Annales de Ciencias Medicas*, for April, Dr. Carlos Vincente Charpantier gives a series of cases illustrating the value of bichromate of potash in secondary and tertiary lesions. Though not altogether new, this treatment is not much known, and yet, from these observations, well deserves to be. The dose is one-fourth of a grain, doubled every three or four days to two or three grains. During the treatment, all alkaline substances are prohibited, as liable to neutralize the chromic acid, which is the active agent. From some experiments on himself, Dr. C. finds the bichromate to lower both pulse and temperature in a marked degree.—*Medical and Surgical Reporter*.

**Syphilitic Disease of the Nose.**— In the *Vierteljahrschrift für Dermatologie und Syphilis*, Band iv. Hft. 1 & 2, SCHUSTER and SANGER recommend the use of the scraping spoon for the removal of syphilitic growths of the nasal cavity, to prevent falling in, and to arrest the disease process. Even perforation of the palate by scraping is at times the lesser of two evils. Artificial illumination should be used. Pathologically the conditions existing vary. There may be—1. simple syphilitic infiltration, the mucous membrane not hypertrophied, with or without alteration of the glands, capillaries or epithelium; 2nd, the same with hypertrophy of the mucous membrane and constriction of the dilated capillaries, by means of cell growth, or, without this, a fact favouring the views of Auspitz and Unna, upon the anatomy of the initial induration, namely, that the vessels remain, as a rule, unobliterated; 3, more severe infiltration of the mucous membrane, passing into syphiloma; 4, epitheliomata of the mucous membrane or condylomata. The subjacent bones and cartilages may show either necrosis with exfoliation, absorbent inflammation, without loss of the mucous membrane, or, plastic osteitis, with the production of spindle cells and connective tissue, passing into bony formation.

The practical points are these: 1. Whereas, ulceration of the mucous membrane has been held by writers to be the sole cause of ulceration of the bone and cartilages of the nose, this need not be the case. That membrane may remain uninjured while the subjacent tissues undergo changes like those of the tibia or frontal bone. 2. A healthy mucous membrane may be caused to ulcerate by mechanical interference, and then this ulceration may extend to the bones, or the disease in subjacent bones pass over to the injured membrane.—*London Med. Record.*

**Carbolate of Chalk in Favus.**—The *Archives of Dermatology* states that Dr. Sawicki uses a paste of pulverized chalk or gypsum, containing 5-10 per cent. of carbolic acid. This is applied all over the head after cutting the hair short. On the third day after, the dressing is removed, the head washed with soft soap and water, and the paste reapplied. A little oil may be added, to render the dressing more pliable. It is said to effect a cure after three or four applications.—*Medical and Surgical Reporter.*



## CANADA

# Medical and Surgical Journal.

MONTREAL, JUNE, 1878.

### THE BRITISH MEDICAL AMENDMENT BILL.

The Bill of Amendment to the British Medical Act of 1858 is still before the House of Commons, and although it has passed the second reading, it is by no means certain that it will become law during the present session. The number of corporate bodies, holding each and all of them licensing powers, has led to unhealthy competition, and in some instances the laxity in examination is such as to be viewed with alarm by the profession generally, as well as by the thinking public. It is true that the public, as a rule, do not estimate the relative value of the diplomas issued by any of those bodies, so that whether a man has obtained an M.D., from a university, or a license from a college, it becomes a matter of small moment when his services are required.

The Bill as introduced appears to give small satisfaction, inasmuch as it does not deal with the objectionable system complained of: that is, it grants permission to two or more bodies to conjoin and form a central examining board, but it does not decide the question at issue by enacting that it shall be compulsory for the licensing bodies in each section of the kingdom, to form themselves into a central board of examiners, and that a diploma or degree shall be recognised as alone conferring an honorary distinction. It would appear that anything short of this will not be acceptable to the profession in Great Britain, and we have no doubt, an act with one door of entrance into the profession will ultimately be obtained.

There is, unquestionably, a desire to obtain such an act, and it certainly looks ungracious on the part of the Scotch and Irish corporations to refuse to surrender privileges which were in

every way admirable for the days in which their charters were granted, but which at the present time are not in accord with the spirit of the age. But while there exists an earnest desire to secure the one portal system for admission of aspirants to the practice of the profession of Medicine and Surgery in Great Britain, it must be borne in mind that in the mother country legislative enactments are difficult to obtain, and when once granted most difficult to over-ride by a bill of amendment. Legislation is, as a rule, more substantially managed in England than in most other countries, any measure of reform is not hastily introduced, nor pushed through without being well considered, and its bearing on the rights of others fully discussed, so that the time of several sessions of the Imperial parliament are usually passed over before a bill which may have been introduced is permitted to pass into law. It is this very system of careful legislation which secures to Great Britain the respect of other nations, no frothy declamation from any number of stump orators being at all likely to guide the councils of the nation.

There can be no doubt of the injury done to the profession by the multiplication of licensing bodies; it is an evil which has been felt in our own country, and nothing can more fully prove this fact than the present system adopted in the United States of America.

The multiplication of licensing bodies for entrance into the liberal professions must result injuriously in any country. This state of things is recognized as a great injury to the medical profession in our own country and also in the neighbouring Union, only perhaps in a more marked degree than that complained of in Great Britain. In Canada we are striving to remedy the evil, and in one Province at least (Ontario) a check has been given to the wholesale licensing of poorly qualified men by the establishment under legislative enactment of a central board of examiners. We should be pleased to record that similar boards existed in all the provinces of the Dominion, or, what in our opinion would be better, a central board for the whole Dominion, having in each Province local boards, but all subject to one head or one general council.

## MCGILL MEDICAL SOCIETY.

The third regular meeting of this Society, for the Summer Session was held May 4th, Dr. James Bell presiding. After reading and confirmation of the minutes, Dr. Ritchie was proposed for membership.

Dr. Osler reported a case of Retro-peritoneal Cancer, or Lympho-sarcoma, in a child, occurring in the practice of Dr. Gardner. At the autopsy a large tumour was found occupying the right half of the abdominal cavity. The right kidney was imbedded in it. The ureter constricted and the pelvis of the kidney somewhat dilated in consequence. Above it was attached to the liver and had eroded one rib.

On section, the appearance was much like that of a foetal brain, being soft and pulpy in consistence with alternate streaks white and grey in color.

Under the microscope were seen sections showing its structure of small round bodies like lymph corpuscles.

Another enormous specimen of the same kind of growth and occurring in the same situation in the abdomen of an adult, was also exhibited. It measured a foot or more in diameter, was lobulated in appearance, of very firm consistence, and had weighed when extracted about 40 lbs.

A third specimen exhibited by Dr. Osler was a kidney taken from a man who had died from a severe burn, the immediate cause of death being the consequent pneumonia. On section, it showed numerous minute white spots of fatty degeneration, the result of the inflammation caused by the burn.

Mr. Lyford exhibited a large, fatty tumour from the tuber ischii of a dog.

Mr. L. D. Mignault read a paper upon a case of Phlegmasia Alba Dolens, under the care of Dr. Fenwick, in the Montreal General Hospital.

G. R., æt. 32, was admitted on April 23rd, two weeks after her first confinement in which she had been attended by a midwife. Slight swelling of the left leg was noticed during the latter part of gestation. The labour was long and difficult, and followed by considerable hæmorrhage. Child still born.

Lochial discharge slight. At times some hæmorrhage. On admission the patient was evidently in a septic condition. Temperature,  $105^{\circ}$ ; pulse 126. Left leg tender and swollen, but does not pit on pressure except about ankle. Patient got gradually worse in spite of all treatment, which consisted chiefly of quinine and salicylic acid, with stimulants. Died on the 28th.

At autopsy the uterus was found to be large. The internal surface of a dirty, greenish hue, with rough shaggy masses adherent at the fundus, and in these numerous veins were found filled with thrombi.

Ovarian veins large. Veins passing from uterus in left lateral ligament plugged with thrombi which extend into the internal iliac, and so to the common and external iliac, completely occluding those vessels. Femoral vein also contained a small thrombus. Nothing of special importance in the other organs.

The reader gave a summary of the different opinions regarding the pathology of the disease, and noticed the bearing on this individual case.

May 11th, 1878.

The regular meeting held this evening, Dr. James Bell in the chair.

Dr. Ross, who was prevented being present by urgent professional duties, requested Dr. Osler to exhibit for him the following:

(1). Finger of a child destroyed by the action of a strong solution of carbolic acid applied by the father. Dr. Ross brought the child to the Hospital and there amputated the finger, which presented all the characteristics of dry gangrene.

(2). A tapeworm of the species *taenia medio-canellata*, or that got by eating measly beef. This Dr. O. thinks is the most common variety in this country, eight to nine-tenths of all the specimens examined by him being such. It differed from the pork tapeworm in not being provided with a circle of hooklets around the head. The specimens exhibited had been very hard to dislodge but had at last yielded to emulsion of pumpkin seeds and oil of the male fern.

The paper of the evening was read by Mr. Lloyd, subject *Taenia Echinococcus*, based on a case in the Montreal General Hospital, under the care of Dr. Ross.

R. A., æt. 25, male, admitted March 22nd, 1878, for pneumonia brought on by exposure while on a spree. Died on the 26th.

*Autopsy.*—On attempting to remove the liver it was found closely adherent to the diaphragm, and on the upper and posterior part was discovered a large echinococcus cyst,  $4\frac{1}{2}$  inches long by 3 inches wide.

On section, the following parts were seen :

(1). External cyst wall, intimately adherent to the liver substance. It is firm and fibrous in consistence, and in several places cartilaginous, with here and there masses of soft cretaceous matter.

(2). Lining this was the proper cyst sac or parent cyst, a thin translucent membrane.

(3). On opening the parent cyst a clear, jelly-like fluid escaped together with several secondary cysts, from the size of a hen's egg to that of a plum.

(4). Besides these were tertiary or grand-daughter cysts, the size of marbles down to that of peas.

(5). On microscopic examination many of the tertiary cysts were found to contain only granular matter, in others were innumerable hydatid heads, 1-60 to 1-100 of an inch in diameter, provided with a circle of hooklets 30 to 40 in number, and four round sucking discs. They were floating free in the fluid and none of the structures known as brood-capsules were met with.

(6). In some of the tertiary cysts the development of a fourth generation could be traced in the form of small bead-like projections from the lining membrane, ranging in size from a pea downwards.

*Taenia Echinococcus* in its mature state is found in the small intestine of the dog and wolf, is not more than  $\frac{1}{4}$  of an inch long, and consists of four segments, including the head with its hooklets, and four sucking discs. The terminal segment is pos-

essed of male and female organs of generation, and contains about 5000 eggs, which escaping obtain entrance to the stomach of man or other parasite bearer. Here the gastric juice dissolves off the shell, and the little embryo contained in it being set free enters the circulation, selects a site for settlement, most commonly the liver, and is there transformed into a simple vesicular body, generally called a hydatid cyst.

From the lining wall of the original cyst a process of germination begins which is repeated in the secondary cysts thus formed, so that one embryo may produce thousands of larvæ or hydatid heads, each capable of developing, (if introduced by any means into the intestine of the dog,) into a mature worm. The disease is rare in America, but so common in England that some writers state that every 7th, others every 3rd, inhabitant is the subject of it.

May 18th, 1878.

The regular meeting of the society was held this evening, Dr. Bell in the chair.

Dr. Osler exhibited (1.) Specimens of different organs from a man who died in the Montreal General Hospital, the subject of Acute General Miliary Tubercle. The lungs and peritoneum were most extensively diseased, being probably infiltrated with the tubercle.

(2.) Thoracic duct of the same subject which was of interest as being obstructed by chronic inflammation of the Intima, and much distended with a fluid containing red blood corpuscles.

(3.) A section of bone from a case of Anæmia, the marrow being in a condition of hyperplasia, and containing nucleated red blood corpuscles, which were probably in a state of transition from marrow cells to red blood cells.

(4.) A kidney taken from a foetus of seven and a half months. The organ was the seat of a Cancer Sarcoma, and was much enlarged, weighing 4 oz. The whole mass of the organ was made up of spindle-shaped cells and renal epithelium.

(5.) A kidney from a child in the practice of Dr. Roddick, the seat of Myelo-sarcoma, consisting of striped muscle cells.

This form of growth is very rare in organs not containing muscle fibre. One has been reported in the uterus, one in the testis and this was the second case reported of one in the kidney. This occurrence in the genito-urinary system was explained by the close connection of the Wolffian body in the foetus with the middle layer of the blastoderm, from which the muscular system is developed.

The paper of the evening was read by Mr. Gray, subject Pyæmia. He reported (1) a case which he met in Western Ontario, occurring in the practice of Dr. Stewart.

A. B., a boy *æt.* 5, who had always been healthy, and who had no history of any constitutional disease, was taken with severe pain in the left hip, which afterwards extended to the other joints. It was diagnosed and treated for a while as a case of acute rheumatism. In two weeks abscesses formed in different situations, chiefly in left hip, left shoulder and in lumbar region, and the patient presented all the symptoms of Pyæmia. As the child refused to take medicine the treatment consisted chiefly of hygienic and supporting measures which were thoroughly carried out, and in the course of a few weeks the symptoms improved and the child made a rapid recovery.

The cause of this case of Pyæmia, as it certainly appeared to be, was obscure. There was no suppurating sore, caries of bone, nor any of the ordinarily accepted causes present, and the reader reasoned that it originated from inhalation of septic particles in the atmosphere.

(2). A case in the Montreal General Hospital: S. S., *æt.* 19, male, had led a very irregular and dissipated life, and lived under bad sanitary conditions. Admitted March 15th, 1878, suffering from pyæmic symptoms. Died April 3rd. No autopsy could be obtained, and the only history of any local sore was that he had been paring a corn, and the symptoms first appeared in that situation. This the reader did not consider of much weight, and thought it more reasonable to suppose that in this case the disease was of miasmatic origin.

Lively discussion followed. Dr. Shepherd thought that the last mentioned case was plainly due to absorption of septic

matter from the corn; he cited cases in which the disease had been set up by so slight a cause as the prick of a pin.

Dr. Vineberg thought that in the first case there might have been acute periostitis present, which is a recognised cause of the disease; might be produced by cold, and was not necessarily followed by caries of bone.

Dr. Bell said he was very sceptical about cold being a cause of acute periostitis.

Mr. Gray explained that the exposure to cold in this case, though not given by the parents as the cause of the disease, was slight, and that it had no weight with him.

### Medical Items and News.

**MONTREAL GENERAL HOSPITAL.**—At the annual meeting of the Board of Governors of this Hospital, held on the 23rd of May, ultimo, at which the election of officers for the ensuing twelve months took place, the Secretary read a letter of resignation from Dr. J. M. Drake, one of the attending Physicians. On motion of Dr. G. W. Campbell, Dr. Drake was unanimously elected on the Consulting Staff of the Hospital. The vacancy in the Attending Medical Staff created by the resignation of Dr. Drake, was filled by the election to that responsible position of William Osler, M.D., L.R.C.P., London. We congratulate our young friend on his appointment, which we regard as in every respect a most judicious selection.

By the steamer of the 25th May, ultimo, Dr. George Ross, Professor of Clinical Medicine, McGill University, and Dr. William Osler, Professor of Institutes of Medicine, McGill University, left for Europe.

Dr. Brown-Séguard has been elected as successor to the late Claude Bernard, as Professor of the College of France. This is a most judicious appointment, as few persons have done as much to elucidate the somewhat obscure features of brain and nervous organization than Brown-Séguard, as well as the rational treatment of brain and nervous affections.



BY LUNSFORD P. VANDELL, M.D., *Professor of Therapeutics and Clinical Medicine in the University of Louisville.*

"A year since, when Dialysed Iron was a novelty, I commended it to the *News*, as a most valuable addition to the *Materia Medica*. Twelve months of additional experience have confirmed my faith in its excellence. The object of this note is to call attention to the great variety of *spurious* preparations sold under the name of Dialysed Iron. In this city I have found nine varieties of so-called Dialysed Iron. Some of these were manufactured here, but most of them were made elsewhere. Genuine Dialysed Iron is nearly tasteless. It has the faintest possible saline flavor and a mere suspicion of roughness. Slightly diluted, its taste recalls that of fresh blood. It is not in the least unpleasant, and does not blacken the teeth or tongue. It seldom or never produces any gastric disturbance or headache, and very rarely constipation. It is exceedingly reliable and rapid as a tonic.

"The *spurious* forms of this drug are without the characteristic of taste and efficacy above enumerated, and chemical analysis readily detects their deficiencies. One of the *spurious* specimens before alluded to, was little less unpleasant than the Tincture of Muriate of Iron, another was excessively acid, another was decidedly saline, another was exceedingly astringent, another was sweetish, another was bitter, and another was seemingly only colored water; another more nearly approached correctness, but only a single specimen possessed the peculiarities of the true article.

"My attention was first directed to this matter through the failure or misbehaviour of the Dialysed Iron in practice. It is but just to say that the good specimen is from WYETH & BROTHER, the original manufacturers of the medicine in America. Wyeth's Dialysed Iron sells at about a dollar a pound. Other makes may be bought at about fifty cents."—*Louisville Medical News.*

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