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PREGNANCY WITH OVARIAN TUMOUR—FOUR
CASES—THREE SUCCESSFUL OVARIOTOMIES.*

BY WILLIAM GARDNER, M.D.,

Professor of Gynæcology, McGill University; Gynæcologist to the Montreal General Hospital.

The association of the gravid state of the uterus with ovarian tumour will be admitted on all hands to possess exceptional interest to the clinician. The danger to a patient thus afflicted, unless the condition be clearly recognized and skilfully dealt with, is very considerable.

An examination of the subject will show that in almost all cases the neoplasm existed before the advent of pregnancy. The impregnation of a woman with ovarian disease of one side need not excite any surprise when the other ovary is healthy. It is surely, however, a reason for wonder when pregnancy occurs with double ovarian tumour, sometimes malignant; and yet a number of such are on record. The only possible explanation of such cases is that pregnancy occurred before complete obliteration of all ova-producing stroma. It would be obviously uncalled-for, before this learned body, to enter into any minute discussion of the subject, yet I venture to remind you of some of the more important dangers to a woman in this grave dilemma.

In the first place, a quiescent or very slowly growing tumour is in most instances with the advent of pregnancy stimulated to rapid growth, with development or great increase of all the

* Read before the Canadian Medical Association, at Montreal, September, 1891.

symptoms. When it is borne in mind that with rapid increase of the tumour, with all the dangers of such a condition, there is a simultaneous development of the uterus, the dangers will be more easily appreciated. But a small tumour may remain small, be subject to no increase of growth, and yet become a source of grave danger. In such cases this is usually from torsion of the pedicle, with subsequent bleeding into the cyst, peritonitis or gangrene, and speedy death unless prompt relief be afforded by the resources of surgery. The dermoid cysts here preserve their well-known exceptionally strong tendencies to torsion of pedicle.

In small tumours the pregnancy may not be interfered with in any way even to full term, and the tumour itself may give no evidence of change, yet with the advent of abortion, premature or full term labour, the woman is at once placed in a position of great danger. This is particularly the case if the tumour be small enough to be still accommodated within the pelvis, as then it is sure to be more or less injured during labour, and the injury has been such as, in many cases on record, to kill the patient.

My experience of the grave condition which I have chosen as the subject of my paper consists of four cases. In three of these ovariectomy was performed at varying stages of pregnancy. In the fourth, ovariectomy was also done, but in the non-pregnant condition. This woman had borne three children after the diagnosis of ovarian tumour had been made. The case is here introduced as an exceptional illustration of how a serious danger may be repeatedly escaped.

My first case was reported in a paper communicated to the *Canada Lancet* for February, 1887. Apart from the main source of interest in the case, it was also interesting in some other particulars. I present the main features, copying from the *Lancet* report:—

“ On the 10th November, 1884, by the advice of my friend Dr. Dugdale of this city, I was consulted in the case of a lady, aged 37, the subject of an abdominal tumour. She had been married eighteen or twenty years, and was the mother of two children—one, a grown-up daughter, born a year after marriage,

the other 11 years of age. A few months after the birth of the last child she began to suffer from cough, hæmoptysis, pain in the chest, dyspnœa, emaciation, and all the other evidences, general and local, of phthisis. The physical signs existed mainly in the right lung, in the apex of which a cavity was diagnosed. So serious were the symptoms at one time, that it was thought by her medical advisers that she had but a few months to live. She rallied, however, and although never long free from cough and expectoration, her general condition became much better, and she had for several years lived in tolerable comfort. To this result the preparation known as Hydroleine had seemed to contribute very much. Between three and four years previous to my seeing the lady a tumour, diagnosed as ovarian, had developed, and when I saw her the abdomen was enlarged thereby equal to pregnancy of six months. All the evidences of cystic ovarian tumour were present, but as it had grown none for a year or two, was not painful, did not seem to be markedly affecting her general health, and as a portion of the tumour occupied the pelvis where it might be adherent, seriously complicating ovariectomy in a delicate woman, I advised non-interference until some indication for prompt action arose. My advice was followed. I did not again see her till early in May, 1886. I then learnt that the lung symptoms had been alternately somewhat active and quiet, the tumour remaining stationary till March, 1886, when it began rapidly to increase in size; menstruation, which had hitherto been quite regular, ceased on 16th February, after a natural flow. There had been nausea and some vomiting. The large increase of the tumour had produced much dyspnœa and pain in the right side of the chest. On some nights the patient had been unable to lie from difficult breathing. I found her emaciated and slightly livid from impeded breathing. The breast signs were doubtful, but on examination the vagina was purple in colour, and both it and the cervix were markedly softened. Enlargement of the uterine body commensurate with the probable duration of pregnancy was tolerably well made out. That part of the tumour which occupied the pelvis at the examination eighteen months before had disappeared upwards. The patient

believed that she was pregnant, and so did her physician. I could only agree. She was watched for a fortnight or more. Her sufferings decidedly increased, and it became apparent that prompt action was necessary. Both patient and her husband (a non-practising physician) urgently desiring the operation, after gentle purgation and dieting for two days, on the 29th May the operation of ovariectomy was done at the home of the lady, Drs. Roddick and Bell assisting. Ether was the anæsthetic used—not, however, without some misgiving as to its possible effect on the lung conditions. The operation was simple and easy—a unilocular cyst of the right ovary, with favourable pedicle and no adhesions. On getting into the belly, it was interesting to note the contrast between the dark red fundus of the womb, as it lay behind the pubes, with the pearl-coloured tumour above it. The after-course of the case was easy and uninterrupted to recovery; no sickness and very little pain; the cough, necessary to get up the expectoration, being the only distressing symptom. The wound healed without a fraction of a drop of pus, either at the line of union or stitch-holes. She was kept in bed four weeks to allow of the cicatrix becoming firm under the strain of the developing uterus. After three months absence in Europe, I called on her in October and found pregnancy advancing, but the enlarging uterus causing considerable distress in breathing. She was confined by her physician at full term on the 26th of November, three days less than six months after the date of operation. Labour terminated naturally after six hours. It was followed by alarming hemorrhage, which led to fainting. It was controlled by ice. The child, a fine healthy boy, weighed nearly 10 lbs. She made an excellent recovery, suffering from nothing of any moment except weakness from loss of blood.”

The second case was in several particulars the most interesting of the series. A woman of 31 was admitted, in January, 1887, to the Montreal General Hospital under my friend Dr. Molson, one of the physicians. She had been married eight years, pregnant four times to full term, and had besides one miscarriage. The last pregnancy was to full term. Delivery fourteen

months previous to present illness ; nursed the child ten months ; menses did not appear till after weaning. Ever since this birth she had suffered left inguinal pain, and four months ago first noticed a lump in this region. Three weeks previous to my first seeing her, soon after a walk, she developed intense abdominal and pelvic pain with vomiting and fever. For these symptoms she was admitted to hospital, and after they had lasted for three weeks I was asked to see her. The pains and other symptoms were still severe. Constipation and retention of urine were present. In the lower zone of the abdomen could be felt a thin-walled, fluctuating, very tender, cystic tumour of the size of a child's head. The uterus was retroverted, fixed, and very tender. On opening the abdomen the tumour was found to be a dermoid cyst of the left ovary, with a long and slender pedicle twisted three and a half turns to the right. There were adhesions to omentum, parietes, and whole pelvic wall ; none were very intimate. The contents were thick and creamy, looking like pus, but coagulated solid instantly on cooling. There were three teeth, one a perfect molar, and a thick bony plate in the cyst-wall, together with a bunch of almost black hair. The cyst-wall was dark-coloured and looked gangrenous. The right ovary being distinctly enlarged and cystic was also removed. The cavity was washed out and a glass drainage-tube introduced and left for five days. The uterus seemed somewhat enlarged and dark-coloured. The thought of pregnancy flashed across my mind, but was not seriously entertained. Recovery was uneventful except for a mild phlebitis of the left leg. She left for home on the twenty-second day. Soon after, it became obvious that she was pregnant, and a little less than eight months after the operation she was confined by Dr. Molson of a living child. Both did well, and were alive and healthy a year after operation.

The last case is that of a young lady who consulted me in September last (1890). She had then been married two years and was the mother of one child, thirteen months old. She was healthy before marriage, but suffered from painful menstruation. She nursed her child for ten months. This child was born in August, 1890. She first menstruated in December, '89, and

again in January, '90. The flow was then absent till (the next) April, when there was a period. Another and the last occurred about May 15th. She had morning sickness quite frequently since July. Has lost much flesh the last few months, and has often felt chilly. For the two months previous to consulting me she had often had abdominal and pelvic pain. Three weeks previous to my first seeing her a very severe paroxysm occurred, and being then in Stratford, Ont., Dr. Welford was called in and discovered a tumour. At my first examination the following was noted: general uniform enlargement of the whole abdomen, greatest girth $38\frac{1}{2}$ inches; ensiform cartilage to pubes $17\frac{1}{2}$; distinct wave-fluctuation; dull percussion note over whole abdomen except a large area on right side, which is clear back to spine and a little below crest of ilium; dull all over left side, clear in the epigastrium, nothing solid to be felt; vagina and cervix purple and distinctly softened; uterus pressed to lower and back region of pelvis, cannot be moved; its body cannot be distinctly outlined. During a fortnight of observation before operation girth increased to 42 inches, and ensiform cartilage to pubes measurement to 18 inches. At some of the examinations the clear percussion area of the right side had diminished, while the note on the left side was slightly more resonant.

Operation on the 10th October, Dr. Alloway assisting. The tumour was found to be of the left ovary, with only one adhesion, and that to the omentum, and a most favourable pedicle. The right ovary quite healthy. The tumour consisted of one enormous cyst with greenish syrupy contents. In the interior, at one spot was an aggregation of small cysts with clear contents, like a bunch of grapes. The recovery was uneventful and rapid, and the patient sat up on the eighteenth day. Pregnancy went on to full term, and she was delivered on 4th March, 1891.

Examination of the literature of the subject and the evidence afforded by the three cases here adduced, lead me to venture the following conclusions:—

1. The association of pregnancy and ovarian tumour, if left to nature, is fraught with danger to the woman, whether the termination be premature or at full term.

2. When left to nature, abortion or premature labour may occur, in either case with frequently fatal result to the mother.

3. When the case proceeds to labour at full term, the result to the mother may be rupture or such other injury to the tumour that fatal peritonitis carries her off.

4. Tapping of the tumour, while it may temporarily relieve tension, is by no means free from danger by injury to the uterus or otherwise, and it does not cure the patient.

5. Ovariectomy with modern precautions is nearly as safe as in the non-gravid condition of the uterus, while the woman is at once cured of a disease which must ultimately demand operation.

6. The second case here related shows that serious complications such as torsion of the pedicle and consequent peritonitis with adhesions, necessitating the use of the drainage-tube for so long a period as five days, does not necessarily lead to abortion.

7. Ovariectomy in the present status of surgery, in the great majority of cases, must be the only proper treatment, and is often urgently demanded to relieve tension.

8. The indication for the operation in the case of small abdominal tumours is even more urgent, because of their great liability to torsion of the pedicle; and in the case of pelvic tumours, by reason of the almost certain rupture or necrosis from compression during labour.

CASE OF IMPENDING FATAL COLLAPSE.

IMMEDIATE RESUSCITATION BY TRANSFUSION OF SALT SOLUTION INTO THE PERITONEAL CAVITY.

By T. JOHNSON-ALLOWAY, M.D.,

Instructor in Gynecology, McGill University, Montreal.

The following case is one of some special interest, and I am induced to publish it in detail:—

Mrs. —, aged 42; married twenty years, three children, youngest 10 years of age; no miscarriages; menstruation regular, duration two days; no menstrual pain, but has of late felt a “gnawing soreness” at epigastrium. Has always been weak and suffered from nervous prostration. By “spells,” has attacks of vomiting without any apparent cause. Has never been jaundiced. During the past six weeks has noticed her abdomen becoming enlarged, but suffered no pain there. The measurement of the abdomen at highest point, on admission into my hospital, was as follows during successive days:

34½ inches.	35 inches.
34½ “	35½ “

The enlargement shows a tendency to increase notwithstanding active purgation.

On a careful abdominal examination it was proved that the enlargement was due to free fluid in the cavity and not to encysted. It was therefore a question as to the cause. After careful consideration I formed the opinion that the ascites depended upon malignant disease. The quantity of ascitic fluid seemed too large for that caused by tubercle; neither had there been a history of previous attacks of peritonitis, so constant in tuberculosis of the peritoneum. The temperature also did not vary from normal standard at any time during her illness. In fact her present condition was great and progressive emaciation, prostration, and abdominal enlargement. After she had been under preparatory treatment for about one week I opened the abdomen. Three gallons of dark-brown, limpid fluid flowed out, and at the bottom of the pelvis I found two large, hard bodies—the ovaries; they were non-adherent, nodular, and

about the size and shape of a human kidney ; they were stony hard to the feel, and attached by a short pedicle to the broad ligament. These ovaries were removed, catgut ligatures being used and the pedicle of each dropped. On further examination of the abdominal contents it was found that the mesenteric glands were much enlarged in certain clusters. The peritoneum was covered with secondary deposits about the size of crystal-like millet seeds. High up in the epigastrium was a large cluster of irregular masses located in the omentum, but which were not thought expedient to remove, ultimate good being very doubtful. The cavity was well cleansed and closed with silkworm gut sutures, leaving a drainage-tube in the lower end of wound. The Trendelenburg posture was used, which doubtless tended greatly to prevent shock on the sudden escape of so large a quantity of fluid. When put to bed her condition was very good, the pulse being about 120 and full.

All went well until about eight hours after the operation. I was then summoned by the nurse, who said the patient was pulseless and in a state of collapse. I found her in a very strange condition. There was not present that collapse we see from hemorrhage, but a restless, sighing, semi-incoherent condition. The radial pulse was a mere flicker, could not be counted, and the heart was evidently strained to its utmost to recover balance. I used hypodermics of brandy and also of ether with extract of digitalis, but no effect whatever was experienced on the heart during the half hour I awaited a change in the pulse ; on the contrary, it was gradually becoming less perceptible at the wrist. The yawning and sighing became more frequent, she became very restless in the bed, the respiration, from being very shallow, became gasping, and, in short, she was rapidly passing into a dying condition. Recognizing the fact that this alarming condition was most probably due to the sudden withdrawal of so large a quantity of fluid (three gallons) from the abdominal cavity, and thereby removing firm and constant pressure from the heart and large abdominal vessels, the patient was in fact bleeding to death within her own vessels. The remedy was evident, and without another moment's loss of time I transfused

about three quarts of sterilized salt solution (temperature 110°) into the abdominal cavity, through the glass drainage-tube fortunately inserted at the operation. When I had transfused this quantity she began to scream and vomit violently. I removed the tube and closed the opening by firm packs of cotton-wool. The strange, and I may say marvellous, result of this procedure now became apparent. The pulse at the wrist was beating full, strong, and counted 110 per minute. The time between the extreme state of collapse described and the taking of the pulse after the transfusion could not have been, at the outside, more than five or six minutes. I do not therefore think this remarkable change was brought about altogether by absorption of the salt solution, but in great part by the mechanical effect of pressure upon the vessels and heart, especially the latter, by lifting the diaphragm upwards. Also, the activity of the absorptive power of the human peritoneum is well known, and is estimated at the rate of five to twelve pints per hour, or the weight of the whole body in from twelve to twenty-four hours. If this estimate be correct, there must have been, in my case, a large quantity of the transfused fluid taken into the circulation in a very few minutes—enough, certainly, to turn the balance in the case of a rapidly failing heart. On the other hand, I do not think pressure of the fluid had all to do with the result, because on examining the abdomen some hours after the transfusion, it was as flat and free from fluid as when the patient left the operating-room. Absorption here was complete, and an intense desire on the part of the blood-vessels for fluid was evidenced by the rapid draining of the peritoneal cavity. The blood-vessels were, however, satisfied with this supply, and the heart's beat did not average more than 115 during the following three and a half weeks she remained in my hospital. There was no effect on the temperature centres, as the highest temperature registered was 101.5° ,* and that only on the second day; it then fell to normal and remained there.

The result of peritoneal transfusion in this case has been exceedingly instructive to me, and I am sure will also be to others

* So-called "fermentation fever."

interested in these sad cases. Death from shock after exhaustive hemorrhage directly the patient leaves the operating table is by no means rare. We do not hear of all of them, because they are not reported, and we can therefore form only an approximate idea of the real mortality. Enemata of salt solution and hypodermic injections of the same have been tried with good results, but both of these methods are slow and limited in regard to the amount of solution which can be used in a given case. Peritoneal transfusion has not these disadvantages. The marvellous rapidity with which the fluid passes into the circulation will immediately resuscitate a failing heart, and places the patient from a dying to a living condition. In all cases where large tumours have been removed from the abdomen, the cavity should be filled with sterilized salt solution, and experience will show its great value during convalescence. I observed also that my patient did not suffer at all from the distressing thirst so noticeable after operations, and attributed so much to the effects of ether instead of to the blood-loss. It is certainly a strange way of giving a patient a drink, but, notwithstanding, it is equally as safe as the usual method, provided the solution is sterile and the operation has been strictly aseptic in technique.

23 MACKAY ST., MONTREAL.

CASE OF PLACENTA PRÆVIA (CENTRALIS).*

By J. A. SPRINGLE, M.D.,

Lecturer on Anatomy, University of Bishop's College, Montreal.

The following report of a case of the above-mentioned somewhat rare condition is interesting, not only on account of the central attachment of the placenta, but also in the absence of some of the many features found in this happily rare complication to labour. A true placenta prævia centralis is exceedingly uncommon. Professor Lusk (*Midwifery*, Ed. 1885) had not observed a case, either central, partial or marginal, in 1500 to 1600 labours. Müller is quoted, giving the statistics as one in a thousand; Lomer, as one in 723 births.

Case Report.—Madame G. O., aged 36 years, French-Canadian, VI-para, sent for me on October 20th last in reference to a profuse bloody flow from the vagina. She was then in the seventh month of her pregnancy. Her previous condition and that of her former pregnancies do not have any bearing upon the case, beyond the fact that she is a sufferer from all the symptoms of an endometritis. During the first four months of her present pregnancy she enjoyed fair health. About the beginning of the fifth month she noticed a slight flow, which, however, soon ceased. From this time forward to the day she first came under my care she has had five bleedings, each successive one more profuse than the preceding one, and leaving her in a more or less exhausted condition. Up to this time she had not taken any particular precautions in regard to her condition. On Oct. 19th she began to bleed profusely, and when seen next day was passing large quantities of both clotted and free fluid red blood. An examination revealed a large bilaterally lacerated cervix and dilated canal, through which could be felt a mass having an extensive attachment about the internal os, and which could be recognized as the placenta. From the unfavourable surroundings it was thought best to temporize, if possible, to allow of the patient's removal to the hospital. After a week in bed and the use of mild sedative measures, she recovered and consented to enter the hospital.

* Read before the Medico-Chirurgical Society of Montreal.

On the 19th November I was surprised to learn that she had not gone to the hospital, and that she had had a profuse hemorrhage while walking in the street. This was due to a shock she had received. I saw her immediately after, and she was then in an exsanguine condition and fainting. The hemorrhage had evidently been enormous. The os was dilated to the size of a twenty-cent piece, the cervix was much softened, and a ragged mass of placental tissue protruded. Firm pressure stopped the flow. With the assistance of Dr. Kenneth Cameron chloroform was administered, ether not being available. But little of the anæsthetic was used, the patient being semi-unconscious. The os having been dilated as much as possible with the fingers, the right hand was then introduced and the thinnest portion of the placenta sought for. This appeared to be that portion situated over the anterior portion of the external os. This was rapidly separated and the membranes ruptured. Both feet were brought down, it having been a vertex presentation. This effectually stopped all hemorrhage. Traction upon the body of the child resulted in a rapid delivery, the placenta following immediately after. The infant was of an average size and was easily resuscitated. There was no post-partum hemorrhage. Upon examining the placenta it was found to be large and thick. The attachment of the cord was central, not marginal, as is so frequently the case in this condition. Moreover, a mass of tissue on its under surface, which I recognized as having occupied the exact centre of the os, corresponded with the centre of the placenta itself. The organ had the characteristic uneven appearance usually seen in such cases. Considering the ease with which delivery was accomplished and the happy result to mother and child, this case is unusual.

Prof. Braxton Hicks, at the Obstetric section of the meeting of the British Medical Association in 1889, laid down the following methods of procedure in such cases:—

- (1) After a diagnosis of placenta prævia is made, proceed as early as possible to terminate pregnancy.
- (2) When once we have commenced to act, we are to remain by our patient.

(3) If the os be fully expanded and the placenta marginal, rupture the membranes and wait to see if the head is soon pushed into the os by the pains.

(4) If there be any slowness or hesitation in this respect, then employ forceps or version.

(5) If the os be small and placenta more or less over it, the placenta is to be carefully detached from around the os. If no further bleeding occur, we may elect to wait an hour or two. But should the os not expand, and if the dilating bags are at hand, the os may be dilated. If it appears the forceps can be admitted easily, they may be used; but if not, version by combined external and internal method may be employed and the os plugged by the leg or breech of the foetus. After this is done the case may be left to nature, with gentle assistance as in foot and breech cases.

(6) If the os be small, and if we have neither forceps nor dilating bags, then combined version should be resorted to, leaving the rest to nature, gently assisted.

(7) If during any of the above manoeuvres sharp bleeding should come on, it is best to turn by combined method and plug by breech.

(8) Where labour occurs before the end of the seventh month, version by combined method, no force following, is the best plan.

Lomer (*Berliner Klinische Wochenschrift*, Dec. 3rd, 1888) recommends version as offering the better chance to the foetus, to which the prognosis is always unfavourable. In the case under consideration, traction upon the foetus offered the only means of saving its life.

A FATAL CASE OF INVERSION OF THE UTERUS.

By C. P. BISSETT, M.D., St. PETERS, N.S.

On the 21st January, at 8 A.M., I was hurriedly called to attend Mrs. S., æt. 23 years, in her second confinement. On my arrival at the house, six miles distant, I was informed that the patient was dead; and so it proved to be, for upon entering the room in which she had been confined I found her blanched and lifeless. The midwife in charge, an ignorant old woman, told me that the labour had been normal, but that a "lump" had followed the delivery of the after-birth. Upon questioning her closely I found that the placenta had been somewhat slow in coming away, and that she had made traction upon the cord conjoined with pressure upon the fundus, whereupon the placenta came, followed immediately by the aforesaid "lump." Symptoms of hemorrhage and shock supervened, followed shortly by death. I examined the body and found that the uterus had been completely inverted and lay between the patient's thighs; the placenta had been completely detached. There can be very little doubt that the accident was caused by faulty management of the third stage of labour. Traction upon the cord is more or less risky even in skilled hands; but when performed by the ignorant or incompetent, the results may be disastrous.

NERVE-STRETCHING IN INVETERATE TRIGEMINAL NEURALGIA.*

By JAMES STEWART, M.D.,

Professor of Clinical Medicine, McGill University.

In the short paper which I have the honour to read before the members of this Association, I confine myself entirely to the consideration of those inveterate cases of trigeminal neuralgia which are usually described under the name of *Epileptiform Neuralgia*. This term includes not only those cases attended by spasm of the facial muscles, but also that class of cases in which the neuralgic paroxysm comes on with great suddenness, lasts a few seconds and persists for years in spite of all the ordinarily employed external

* Read at the meeting of the Association of American Physicians, at Washington, September, 1891.

and internal remedies. During the past two years, through the kindness of my colleagues, three cases of inveterate trigeminal neuralgia have come under my observation, and as the result of treatment in all three was fairly satisfactory, I will give a brief account of them, and afterwards refer to those published cases where a similar treatment was carried out.

CASE I.—INVETERATE TRIGEMINAL NEURALGIA CONFINED TO THE LEFT INFRA-ORBITAL BRANCH. NERVE STRETCHING. COMPLETE RELIEF FOR THIRTEEN MONTHS.

A married woman, aged 50, first came under observation in November 1889, complaining of severe neuralgic pains in the left infra-orbital region. Her previous health was good. There is no history of neuroses in her large family connection. The first paroxysm of neuralgia came on twelve years previously, and was attended by a profuse flow of saliva. For a period of about two years she had no recurrence of the attacks, but during the past ten years she had many attacks daily during the winter months of these years. She was entirely free during the summer months. During all these years she had been perseveringly treated by many different physicians, but with very little relief. When I saw her she was willing to submit to any measures whatever to purchase even temporary relief from her cruel suffering. I advised stretching the nerve, and Dr. Shepherd of Montreal kindly consented to undertake the operation, which he performed in December 1889, in Montreal. She remained entirely free from pain for thirteen months after the operation. In January 1891, the pain returned in the same spot with much of its old-time severity, but only lasted a few weeks. For the past six months she has remained entirely free.—(Reported by Dr. Weagant of Dickinson's Landing.)

There can be no question that the operation in this case was eminently beneficial, complete relief lasting for fully thirteen months after its performance.

CASE II.—EPILEPTIFORM NEURALGIA OF THE RIGHT INFRA-ORBITAL NERVE OF FOUR YEARS STANDING. STRETCHING OF THE AFFECTED NERVE, FOLLOWED BY COMPLETE RELIEF FOR FOURTEEN MONTHS.

This patient, a woman aged 65 years (a patient of Dr. Ross), was never affected with neuralgia until after her sixty-first year.

The family history did not show any tendency to neurotic troubles. Her previous health was fair. She had, however, borne more than an ordinary share of the world's cark and care. For a period of four years she has been troubled with severe darting pains in the region of the right infra-orbital nerve, and for several months before the operation the paroxysms had assumed an extremely severe form. For hours and even for a day or two at a time she was not infrequently compelled to remain perfectly quiet in the endeavour to lessen the number of attacks. During this time she could neither speak or eat without the occurrence of a paroxysm. The severer attacks were usually accompanied by twitching of the muscles of the same side of the face. All the usually employed remedies in this disease were successively resorted to, with little or no relief. In this rather hopeless state she readily consented to submit to any operation that was even likely to bring partial relief. Dr. Shepherd stretched the right infra-orbital nerve in Feb. 1890, and, with the exception of one severe paroxysm a few hours after the performance of the operation, the patient remained entirely free from pain for a period of fourteen months. After this she had on several occasions slight recurring attacks at considerable intervals, but the intensity of the pain never reached what it did in the period previous to the operation.

This patient died in August, 1891, from enteritis.

CASE III.—SEVERE NEURALGIA OF THE RIGHT INFRA-ORBITAL NERVE. NERVE-STRETCHING, FOLLOWED BY FOUR MONTHS RELIEF.

I am indebted to Dr. Buller of Montreal for the details of this case.

The patient, a woman 80 years of age, but looking much younger, being well nourished and of fresh complexion. Fifteen years ago she received a severe injury to the right shoulder, involving the brachial plexus, but from which she appears to have entirely recovered. She, however, dates her facial neuralgia from this period. The pain is described at times as dull, but usually of a sharp, darting nature, and is attended by extreme sensitiveness of the inner part of the right upper alveolus. All the teeth in the right upper jaw have been removed, but with little or no beneficial result. The pain, though chiefly located as described, at times affects the whole side of the face, brow and temple. The supra and infra orbital foramina are rather

more sensitive to pressure than the surrounding parts. Seven years ago she had an attack of subacute glaucoma of the right eye (painful side), for which an iridectomy was performed successfully, inasmuch as the tension has remained normal ever since, and vision, although defective, improved after the operation. The left eye has at no time shown any signs of glaucoma. On January 12th of the present year Dr. Buller says: "I stretched the infra-orbital very forcibly, but, as far as I could judge, without any solution of its continuity. Four days after, on examination, the wound was found completely healed, and all pain had ceased from the date of the operation." Her attending physician reports at this time complete loss of sensation and reflexes on the right side of the tonsil, uvula and soft palate. Twenty-five days after the operation he writes: "The operation was very successful as far as relieving the pain, but the loss of sensation already referred to still persists, and in addition there is a complaint of a wooden sensation in the region of the face corresponding to the distribution of the infra-orbital nerve. These parts are also distinctly anæsthetic." In this case, four months after the operation, there was a return of the old neuralgic pain. Six months after the operation Dr. Buller carefully examined the patient and reports: "The stiff, board-like feeling she complained of in the right upper lip and adjacent parts has disappeared. The paroxysms of pain are less frequent and less severe. She speaks of them as being quite bearable now in comparison to what she formerly suffered."

In the three cases reported we had complete relief lasting in one for fourteen months, in another about twelve months, and in the third for four months. These results, although not of a very enduring character, still are sufficiently pronounced to much more than counterbalance the slight danger and distress attending the operations performed. In each case the patient would willingly have purchased even a few weeks relief at greater cost.

A large number of cases of trigeminal neuralgia treated by nerve-stretching have been reported, but, unfortunately, the vast majority of these reports are worthless as an aid to settle the question as to the permanent value of the operation. It is very exceptional to find a case of nerve-stretching reported where very marked or complete relief has not taken place, and as the

great majority of these cases are reported within six months after the operation, they go to swell the list of alleged completely successful cases. There is no doubt, I think, that the great majority of these relapse, are not again reported, and erroneous conclusions as to the success of the procedure drawn.

I have endeavoured to obtain the result of nerve-stretching in all those cases in which the state of the patient was reported nine months and upward after the operation. It is surprising how few cases observed for this length of time are obtainable. Fully 90 per cent. are reported before six months have elapsed. In Dr. Chandler's and Prof. Agnew's collections, with the exception of one case, the longest time a patient was under observation was seven and a half months.

I have only been able to find a record of eleven cases in which the observation of the patient extended beyond nine months, exclusive of the cases I have reported. Mr. Walsham, of St. Bartholomew's Hospital, reports three cases of complete relief lasting three years, fourteen and thirteen months respectively. Grainger Stewart reports one that remained well one year after, and the late Mr. Spence reports one nine months after operation still free from pain. Lefort reports one case where relief lasted more than one year, and Lagrange three extending over three years, one extending over two years, and one over eighteen months.

It would be very interesting to have a report on all cases operated in from one to two years after the operation. There is no reason to doubt that the percentage where permanent relief is obtained is very small, probably not more than five per cent. It is contended by some surgeons that the relief obtained is not sufficient to counterbalance the annoyance of the operation to the patient. In judging this question, we must take into consideration the fact that in the great majority of cases we obtain marked relief for a few months, a relief which is a great boon to the distressed patient; and further, the operation can be repeated with the probability of a continuance of relief. If repeated nerve-stretching fails eventually to give the relief demanded, other but more severe operative measures can be resorted to.

These are the performance of neurectomy, and in the case of the infra-orbital the removal of Meckel's ganglion, and ligation of the common carotid. Dr. Fowler (*Annals of Surgery*, 1886) has collected 83 cases in which portions of one or more of the branches of the fifth nerve have been removed. In fully 25 per cent. of these cases relief from pain lasting a year and upward followed. In Wagner's table (*Archiv. für Chirurgie*) of 135 neurectomies, 18 complete cures are reported, and in 20 cases relief lasted from one to three years. There are several other cases of neurectomy reported since Fowler's and Wagner's tables have been published. Including these, I have been able to collect in all 250 cases, and I think I am safe in saying that in fully 20 per cent. we have relief extending from one to three years, and probably 10 per cent. of complete cures. The showing from neurectomy is, therefore, considerably better than from nerve-stretching, but it must be remembered that neurectomy is an operation not devoid of danger.

In Wagner's collection there were six deaths; in Dr. Fowler's, no fatal results are reported. As Dr. Wagner's cases occurred in pre-antiseptic days, the mode of operating probably accounts for the unfavourable results in so many cases. Nerve-stretching is a mild operation as compared with an extensive neurectomy, and should, I think, be always preferred to it. Another important reason for preferring nerve-stretching as the preliminary operation is that if it fails it may be repeated several times, while if an extensive neurectomy is first performed, no operation except the grave one of ligating the common carotid can be performed. As the great majority of cases of epileptiform neuralgia are due to central mischief, it follows that after the failure of an extensive neurectomy neither nerve-stretching nor a further neurectomy is possible.

From our present experience of nerve-stretching in inveterate trigeminal neuralgia, I believe the following conclusions are justifiable :

- 1- Nerve-stretching gives either complete or great relief in the majority of cases.
2. Relief is not permanent in more than 5 per cent. of cases.

3. If the pain should return, the operation should be repeated, even several times, before resorting to a neurectomy, or ligature of the common carotid.

4. If the pain is not strictly and always limited to one branch of the nerve, several branches should be stretched.

5. As relief does not always immediately follow the stretching, a second operation should not be undertaken until some time has elapsed.

Hospital Reports.

MONTREAL GENERAL HOSPITAL.

REPORT OF A CASE OF TYPHOID FEVER FROM DR. STEWART'S WARDS.

The following case of typhoid is especially noteworthy from the very unusual course of the pyrexia, the frequent falls to the normal having on several occasions made the diagnosis a matter of doubt. Looking back on the entire course of the disease, there can, we think, be no question but what the case was one of undoubted typhoid fever. In the course of typhoid it is unusual to meet with falls of the temperature to the normal, and then from the following conditions: (1) intestinal hemorrhage; (2) severe diarrhoea; (3) from the effects of antipyretics; (4) in patients with a neurotic history, especially of insanity, we sometimes meet with a temperature even below the normal and extending over some days in the course of typhoid. In such case we have, however, a semi-maniacal condition.

All the above causes can be excluded in the case under consideration, with the possible exception of the fall occurring after the second bath. Throughout the course of the disease the bowels were constipated, and there was no hemorrhage from the intestines. The mind remained clear throughout. Although antipyretics were used, they were administered in such doses and at such times as to have had little or no influence in bringing about the unusual course of the pyrexia.

The following clear account of this case is by Thos. Jameson, clinical clerk:—

Mrs. T—, aged 26, a native of England, was admitted to the Montreal General Hospital on October 31st, 1891, complaining of the usual prodromal symptoms of typhoid—severe frontal headache and indefinite bodily pains. She was a pale, poorly-nourished woman, but on physical examination nothing abnormal was discovered except a slightly enlarged spleen, which could only be detected on the most careful palpation. Tongue was dry and thickly coated in the centre with a white fur, but the edges and tip were clean. Temperature 103.5° at noon; pulse 88, full and strong. A provisional diagnosis of typhoid fever was made, and the temperature directed to be taken every two hours.

The next day after admission (Nov. 1st), at 2 P.M., her temperature was $103\frac{2}{3}^{\circ}$. A cold bath was given, lasting ten minutes; temperature of water was 72°F . The patient objected very strongly to the bath, and shivered a good deal during the bath and after she was taken out. The bath was followed by a fall in her temperature of four degrees, it being $99\frac{1}{3}^{\circ}$ half an hour after, but it did not remain down very long, for at 5 P.M. it had again reached 103° . Another bath was given, lasting nine minutes, which caused a fall in the temperature of four and a half degrees, her temperature being 98.5° half an hour after the bath. The temperature soon began to rise again, and by two o'clock the next morning (Nov. 2nd) it was $102\frac{2}{3}^{\circ}$; but at 6 A.M. it had fallen to 99° , and by 10 A.M. it was subnormal, being down to 97.5° . This remarkable fall was not accompanied by any signs of collapse; on the contrary, the patient looked bright and well, her face had lost that dull, languid expression, and she said her headache had entirely disappeared. This sudden drop threw some doubt on the diagnosis of typhoid, and the baths were ordered to be discontinued. The temperature remained subnormal until late in the afternoon, when it slowly began to rise, and by 8 P.M. reached $101\frac{2}{3}^{\circ}$. On the following morning (Nov. 3rd), at 6, it was 102° , but by 10 o'clock it had again dropped to 99° ; it reached 102° at 2 P.M., but by 8 P.M. it had again dropped to 99° .

The general condition during these three days was remarkable. She complained of no pain, was bright and cheerful, and said

she felt quite well ; but on the morning of Nov. 4th, the tenth day of her illness and the fifth day since her admission, the diagnosis of typhoid was confirmed by the appearance of the characteristic rose-coloured spots over the lumbar and lower dorsal regions. A change was also noticed in the condition of the patient ; she became dull and stupid, and her face assumed that peculiar languid expression so characteristic of typhoid. It is interesting to note that the day before the spots appeared the urine gave a very marked reaction with Erlich's test for typhoid. The day after the spots appeared the patient complained of pain and stiffness in the finger-joints and of shooting pains in the knee-joints, extending down the leg. On examination, there was found to be hyperæsthesia of both lower extremities with absence of the patellar reflexes. There was no swelling nor tenderness on pressure over any of the joints ; some spinal complication was feared, but these symptoms disappeared in a few days without any special treatment.

The temperature continued to be most remarkably irregular ; the day after the spots appeared it was down to normal, and on the second after that—the eighth day after admission and about the thirteenth day of the disease—it had again fallen to sub-normal, being at 10 A.M. 97.5° . These remissions were not accompanied by any improvement in the patient's general condition ; on the contrary, she complained of a very distressing sense of giddiness, and was extremely weak. Nor could the condition of the bowels throw any light on the remarkable temperature, for she was constipated and the bowels moved by enemata of glycerine ; the action of the bowels was not followed by any fall in the temperature.

For the next week the temperature curve touched 99° nine different times, and it reached the normal three times. These remissions were chiefly in the morning, the lowest point being generally reached between 10 and 12 in the forenoon. The evening exacerbations only reached 103° twice, the average being about 103° .

The patient now developed a bronchitis, and râles could be heard over the whole of both lungs ; cough was troublesome, but

the patient was too weak to expectorate. The skin now began to desquamate, the spots having almost entirely disappeared.

On the third week of her stay in the hospital the temperature curve assumed a more regular character; it only reached normal twice and the evening exacerbations touching 103° three times. During this week the patient began to improve, said she felt much better, and complained of being very hungry. Up to this time she was kept exclusively on milk diet, but complaining that she tired of milk, she was allowed some chicken broth.

During the fourth week in the hospital, the fifth week of the disease, the temperature became much higher; the evening exacerbations four times almost touched 104° , and the morning remissions being seldom lower than 101° . During the early part of this week a vaginal discharge occurred of a dark-brown colour, lasting for two days. Previous to her illness the patient was not menstruating, as she was nursing an infant.

The temperature during the sixth week of the disease became more of a septic type, the evening exacerbations reaching 104° and the morning remissions falling as low as 101° . On the 37th day of the disease (Dec. 1st) the temperature fell to 99° at 4 A.M., but by four in the afternoon it was 104° . The next day it did not go below 101° , but on the following morning, the 39th day of the disease, at 4 A.M., the temperature fell to sub-normal, reaching as low as $97\frac{2}{5}^{\circ}$. At 12 o'clock the evening before it was only $101\frac{2}{3}^{\circ}$, yet the patient was delirious. For four days previous to this the patient was taking ten grains of antipyrine daily at 12 o'clock noon. It had, however, but little effect on the temperature curve.

As before, no cause could be found for this sudden drop, nor did the general condition of the patient vary with the changes in the temperature. She still continued very weak, and was entirely unable to even turn herself in the bed.

On Dec. 5th, the 41st day of the disease, at 4 P.M., the temperature was 102° ; the antipyrine had been discontinued for twenty-four hours. Three grains of phenacetin ordered to be given every two hours. The first dose was given at 2 P.M.; at four the temperature was 102° ; at six the patient was asleep;

at eight the temperature had fallen to 98.5° ; by some misunderstanding the nurse gave her $1\frac{1}{2}$ grains of phenacetin at nine, and by 10 P.M. the temperature had fallen to 97.5° . At 2 A.M. (Dec. 6) the temperature was $96\frac{2}{3}^{\circ}$. Patient complained of being bitterly cold; external heat was applied, and one ounce of port wine given every three hours until 8 A.M., by which time her temperature had again reached $100\frac{1}{2}$, and she felt better. The phenacetin was still continued. By 8 P.M. the temperature was 102° , but by midnight it fell to 99° . The phenacetin was now ordered not to be given unless temperature rose to 101° .

For the next week, the eighth week of the disease, the temperature began to fall by lysis. Three grains of phenacetin was given every time the temperature reached 101° ; following each dose the temperature usually fell from one to two degrees and patient perspired a little, and quite often she complained of being cold. On Dec. 11th, in addition to chicken broth, beef-tea and gruel, which she had been taking for the last sixteen days, she was allowed some chicken. On this diet she improved markedly, her temperature remaining almost normal; her bronchitis also rapidly disappeared, and the patient seemed on the road towards a rapid recovery; but on the evening of Dec. 17th, the 54th day of the disease, the ward got rather cold, and the patient complained of being chilly. By 8 o'clock the next morning her temperature once more rose to 103° . Three grains of phenacetin was given, and by noon it had fallen to 101° , but by 2 P.M. it was again 103° ; three grains of phenacetin was given, and by four it had fallen to 101° and the patient fell into a quiet sleep, but by 8 P.M. the temperature once more reached 103° . Phenacetin was once more given, with a similar result to the above. It was now evident that there was a distinct relapse. Slight diarrhoea occurred, and the patient complained of a good deal of abdominal pain. She was once more put on milk and lime water, opiates given to relieve the pain, and one ounce of port wine given every four hours. Phenacetin was given every time the temperature rose to 101° .

For the next seven days the temperature remained high, but with marked morning remissions. On Dec. 29th, the 65th day

of the disease, at 4 A.M., the temperature fell to 97°, and did not rise much above normal, but for the next five days the morning temperatures were higher than the evening. On Dec. 22nd, the 58th day of the disease, the patient was allowed gruel and egg-nogg in addition to milk.

With the fall in temperature the diet was gradually increased, and by Jan. 2nd, 1892, the 69th day of the disease, she was once more on full diet. The patient now began to recover rapidly, was allowed up, and on Saturday, Jan. 9th, she was, at her own request, allowed to go home, it being 75 days since she first began to feel ill.

The urine in the first couple of weeks was diminished in quantity and decidedly febrile, yet it never at any time contained albumen or casts. The patient was constipated throughout, her bowels being moved by enemata of glycerine; only once, on the night of Nov. 28th, the 34th day of the disease, did she have a typical typhoid stool.

ACUTE MILIARY TUBERCULOSIS ORIGINATING FROM A DISEASED BRONCHIAL GLAND—FATAL ON THE 32ND DAY.

The following case is a typical example of acute miliary tuberculosis in its origin, symptoms, physical signs and termination. During the third week there was evidence of pulmonary consolidation, which passed completely away in the course of a few days, while at the same time the sputum contained numerous diplococci pneumoniae. This may be taken as evidence of a croupous pneumonia complicating the tubercular process, which disappeared before death, for at the post-mortem no trace of pneumonia was found.

The patient was admitted to the hospital for tonsillitis, but it was from the very first clearly evident, from the appearance of the patient, that we had a much more serious trouble to deal with. The livid lips and disturbed breathing told us of a condition of things much more grave than tonsillitis. This respiratory disturbance was prominent for days before there was any physical evidence of disease of the lungs.

The case is a good example of how important it is to study the physiognomy of disease.

(Reported by B. F. Boyce.)

A. L., aged 20, brunette, a large muscular, well-developed young woman, entered the Montreal General Hospital November 4th, 1891, complaining of nausea, headache and sore throat. Previous to July of that year she had enjoyed good health; on the 21st of that month she entered this hospital with pain and tenderness in her right elbow and wrist joints and also a feeling of tightness in her chest. Under the salicylate treatment she speedily recovered, and was discharged August 9th, when she returned to her occupation as cook, gaining steadily in flesh and strength until the latter part of October.

During the last week of October, although without any definite ailment, she was conscious of not feeling well, but continued her work as usual. On the evening of the 30th, while over-heated and perspiring freely, she sat down to tea in the draught of an open door and window; before the meal was finished she had a feeling of chilliness accompanied by shivering; this was of short duration, and she went to bed at 10 P.M. feeling apparently quite well. Soon after she had another chill, lasting about an hour, followed by intense heat, sickness and vomiting; she vomited several times during the night, had a throbbing headache, and everything seemed to be whirling around. In the morning she was not much better, and was unable to retain anything on her stomach during the day. Next morning her throat was sore and the other symptoms were but little, if any, improved, and she remained in about the same condition until her readmittance on November 4th, when I first saw her; at that time she was lying on her left side, with knees drawn up, and had marked lividity of her face and hands, more especially of the lips, ears and fingertips, with great dyspnoea, accelerated respirations (32 per minute), a soft, rapid pulse of 108, and a temperature of 101.5°.

Physical examination of the chest revealed nothing abnormal; there was a slight enlargement of the spleen and the abdomen moderately distended with gas. Her throat was congested, the left tonsil being swollen, and the mouths of the ducts were covered

with small patches of muco-purulent secretion ; the tongue was heavily coated with a white fur, and her teeth were clean and well preserved. She was coughing occasionally and raised a small amount of muco-purulent sputum, a microscopical examination of which revealed nothing pathological. The vomiting had ceased, but anorexia and a nauseous feeling remained. Her urine was high-coloured, acid in reaction, specific gravity 1031 ; it contained 20 grains of urea per ounce, and she passed 24 ounces during the first twenty-four hours of her stay in the hospital.

From these symptoms it was clear that the sore throat was not the principal trouble, and acute miliary tuberculosis was suspected, although a careful search showed no enlarged lymphatic glands, and her family and personal history was excellent. During the first week of her stay in the hospital the sore throat and headache disappeared, but the lividity and dyspnoea were constant ; her cough became troublesome at night and her sleep was broken. A microscopical examination of blood and sputum revealed nothing pathological. An average of the respirations for the week was 34 in the morning and 43 in the evening ; her pulse was 121 morning and evening, and her temperature varied between 100° and 103°.

Early in the second week crepitant râles were heard at the lower angle of the right scapula ; next day dullness appeared in the right base, and crepitant râles were audible in both infra-clavicular and interscapular spaces. Dyspnoea was constant, the lividity not so marked ; at times a hot-water bottle was used to keep her feet warm, her appetite improved considerably, several small hemorrhages occurred from the nasal mucous membrane, and blood appeared in the sputum, which contained numerous diplococci pneumoniae (Friedländer). Her temperature was not so high nor her pulse so fast, but her respirations were faster than in the preceding week.

During the early part of the third week she seemed to be improving, but soon changed for the worse ; her cough became very troublesome and was frequently followed by vomiting ; dullness was present over both bases, and large crepitant râles were present over the whole chest ; she was losing flesh rapidly, while

the dyspnœa and lividity were becoming more exaggerated. Nothing could be found in the sputum; the temperature was more variable, the pulse slower, and the breathing faster than in the preceding week.

The fourth week was marked by rapid failure; she would take scarcely any nourishment; the dyspnœa was very distressing; her cough incessant and expectoration scanty, and contained nothing abnormal. There was no obvious change in her chest from that of the preceding week; she was very restless, and slept very little except when under the influence of morphia; her temperature was irregular; the pulse and respirations still more accelerated.

During the fifth week, no physical examination of her chest was made; she was greatly emaciated and suffered intense agony from dyspnœa, the respirations at times reaching 73 per minute; when conscious, she cried and moaned incessantly; her face and hands were a livid purple and the veins of her neck prominent. Her temperature varied from 97° to 101°; the pulse was very fast and small, reaching 160, and at times of a running character, so that it was necessary to count it with a stethoscope over the apex. She died December 5th, after thirty-two days illness. Obstinate constipation lasted throughout the entire illness, and at no time could any bacilli be found.

Post-mortem examination.—On opening the chest the lungs did not collapse; a slight adhesion was present at the apex of the right lung, between an accessory fourth lobe and the parietal pleura; on removing the lungs numerous miliary tubercles could be seen as small glistening formations from $\frac{1}{2}$ to 1 mm. in diameter, lying under the visceral pleura; on section, they were seen to be a mass of tubercles which were distinctly larger in the apices than in the bases; there were no consolidations or cavities. The spleen, which was slightly enlarged, also contained a few large tubercles, as did the kidneys; no tubercles were found in the brain, liver, mesentery or intestines. On removing the trachea a large suppurating gland about an inch long by half an inch thick was found on the right bronchus, and a little higher another about the same size in which no degeneration had taken

place. The heart was normal, but contained large dark clots in all its chambers; the large veins were also engorged with blood.

Histological examination of lungs by H. A. Lafleur, M.D.—There were numerous miliary tubercles throughout the lung; most of these were single, but others were composed of two or three smaller tubercles; one or more giant cells were present in each. In a few tubercles the central portion did not take the stain well, showing commencing caseation. There was also a diffuse tuberculous infiltration around a number of the blood-vessels; the alveoli adjacent to the tubercular nodules contained altered red blood cells and loose epithelial cells derived from the alveolar wall.

Correspondence.

MUNICH, BAVARIA, Jan. 20th, 1892.

To the Editors of THE MONTREAL MEDICAL JOURNAL.

SIRS,—In response to your invitation to send you a little account of my visit to the hospitals and École de Médecine of Paris, I send you the following. In doing so I feel I must apologise for its sketchy character, but I have found it difficult to know what would interest your readers most. What I have to say may at least be of some interest and help to any who are contemplating a visit to Paris in the near future.

The École de Médecine and the principal hospitals of Paris are situated on the left bank of the Seine, over in the Latin Quarter. The École de Médecine, on the Boulevard St. Germain, consists of two very handsome large buildings. The école proper contains the large lecture amphitheatres, Orfila musée, and the new library. On the other side of the rue de l'École de Médecine is the very fine École Pratique, containing all the laboratories, etc., which are magnificently equipped. The clinics and lectures are entirely free to all, there being no fees except for private courses. On the bulletin boards in the court-yard of the École de Médecine one finds all the information one needs about the lectures, clinics, etc. The new library, containing 60,000 volumes, was opened in the latter part of December, and

is very fine indeed. In the reading-room one afternoon I calculated that there were no less than 480 students at the different tables. The Faculty has about 2,800 students in all, there being quite a large number of female students, chiefly Russians, who take their clinics with the men. There are two museums in connection with the *École de Médecine*. The largest is the *Musée Orfila*, in which I noticed a very fine collection of injected specimens of the absorbent system, and a large osteological collection, all very conveniently arranged. The *Musée Dupuytren* is smaller and is in a very old building, once used as a monk's refectory ; it contains many very interesting specimens.

Most of the clinics take place at 9 A.M., there being none in the afternoon, so that it is rather a difficult matter to arrange one's time to the best advantage.

Being chiefly interested in obstetrics, I directed my steps to the *Clinic d'Accouchement* in *Rue d'Assas*, over which Prof. Tarnier presides. It contains over 300 beds and is a very elegantly appointed hospital, as are most of those I have seen, though I must say that as far as nurses and nursing are concerned the English and American hospitals are far ahead. Prof. Tarnier I found to be very kind indeed ; he and his chef de clinic, Dr. Tissier, gave me every opportunity to see all the work of the hospital. Prof. Tarnier's morning's work is as follows : he meets his students in the labour room shortly after 9 o'clock, and there goes over any cases that may be in progress ; this is followed by a visit round the wards. He is very thoughtful in calling the attention of the students to all cases of interest and in explaining the treatment, etc. His enormous experience makes these bedside talks of great value, and they are evidently highly appreciated by his followers, who pay the closest attention to his remarks, which are rather difficult to hear as he talks in a very low tone. After the ward visit he gives a lecture for over an hour in the theatre. I heard him give two very fine series of lectures on eclampsia and rupture of the uterus. His style is very practical and clear, but he is not at all an eloquent lecturer.

I should say that the most popular obstetrician in France is Prof. Pinard, well known for his work on *Abdominal Palpation*.

He has charge of the Clinic Bandeloque on Boulevard Port Royal, a hospital which contains about 100 beds. Prof. Pinard is a much younger man than Prof. Tarnier, and is full of energy and enthusiasm for his work. Most interesting cases are to be seen in his clinic, which is most brilliant and practical, and always crowded. Every Wednesday morning is devoted to gynæcology, as a rule an operation taking place, Dr. Segond being the operator. I saw him one day do a vaginal hysterectomy for uterine myoma in less than twenty-five minutes, using clamps on the broad ligaments and no ligatures or sutures whatever. He always uses silver wire as sutures for abdominal cases and dry dressing, a strip of iodoform gauze being laid over the wound, covered by a pad of absorbent cotton and a binder applied very tightly. I never saw him use a drainage tube.

Prof. Budin, of the Hôpital de la Charité, is a very methodical and careful clinical teacher. His section of the hôpital has been rebuilt lately and is now a typical maternity, certainly the best managed in Paris.

The hypodermic injection of dog serum (about .05 cc. every second or third day) in cases of feebly nourished and wasting infants is being tried in Paris with very satisfactory results indeed, a great many cases showing a steady increase in weight dating from the first injection.

The operation of symphysiotomy, in cases of contracted conjugate, is likely to come into fashion again. Prof. Pinard last summer visited Naples, where he saw thirty-two cases in which the operation had been done without one bad result, the patient walking in fifteen days. He speaks very highly of the operation, claiming that a gain of at least two cm. can be obtained in most cases. He is going to do the operation on the first suitable case.

I met several Englishmen and two or three Montrealers, Laval men, who were taking post-graduate courses over here.

There are plenty of good rooms to be had in the Latin Quarter for about the same price as one would pay in Montreal, but on the whole living in Paris in winter is more expensive than at home.

I spent a couple of mornings at Prof. Charcot's clinic in that

hospital of wonders, the Salpêtrière, which is an enormous institution, containing about 3,600 beds, being a kind of workhouse or home for old women chiefly. Prof. Charcot's clinic is given on Tuesday and Friday of each week at 10 o'clock, but in order to obtain a good place one must be there shortly after nine, as the clinic is always large and the room a poor one for the purpose, being long and narrow, and most of the seats are on the level. On the platform at one end of the room were several patients, a couple of large black-boards, a large table and several chairs. On one of the black-boards was painted a table of the symptoms of Disseminated Sclerosis, or "Schlerose en plaques" as Charcot calls it, divided into cerebral, spinal and anomalous, these being subdivided into positive and negative, symptoms. Promptly at 10 o'clock Prof. Charcot came into the room, followed by his chef de clinic and a few of the house staff, among whom was his son. He took his seat at the table, half facing the audience, and then for an hour he lectured on "schlerose en plaques," using no notes, but illustrating his remarks from time to time by drawing on a black-board at his side. His style is clear and to the point; in fact he made me think of our late Dean, Dr. Howard, in the way he would act the disease before us, so as to impress upon us the symptom he was talking about. As he went along he brought forward case after case showing the different types and stages of the disease. In the second clinic which I heard him give he took up the differential diagnosis. He would place two cases alongside each other, one of disseminated sclerosis and one of some other disease, drawing our attention to the differences of the two when thus compared. From 11 to 12 o'clock he devoted to the examination of cases which had been saved for him from the daily clinic of the hospital. This was certainly not the least valuable part of the morning's work, for one could not listen to his questions and watch his method of examining each patient without learning a great deal.

An account of a visit paid to the Pasteur Institute may prove interesting to your readers. The Institute is quite a fine large building standing back from the street. On the grass plot in front is a figure of a boy struggling with a mad dog, in bronze, which typifies at least one branch of the work done in the Insti-

tute. We entered a large waiting-room at the side, which contained about sixty patients of all nationalities. I noticed among them two Arabs in their native dress, a Chinamen, a Japanese, besides several English people. The treatment is gratuitous only, so rich and poor have alike to wait their turn. The porter took our cards into the professor's room, and in a few moments we were ushered into the presence of the great man. He greeted us very kindly, and after a few remarks called an assistant, who showed us about a bit, and explained the treatment to us. A very careful record is kept of each patient, the state of the dog, site and extent of the wounds, date when bitten, date of commencement of treatment, etc., all being recorded. It seems bites about the face are considered the most dangerous. As a rule, from twenty to sixty injections in all are given at intervals of a day or two. The strength of the solution is gradually increased as the treatment goes on, the duration of the treatment depending on the site and character of the wounds. The fluid itself is an opaque milky-looking substance with but little odour. The patients come in in turn, with the clothing about the abdomen loosened so that a small area of skin can be reached on either side. The patient is held by and leans on an assistant, as most start when the needle is introduced. The site of the injection having been cleansed with a solution of carbolic acid, about 10 c.c. of the fluid is injected deeply into the tissues with an ordinary large hypodermic needle. As a rule, an injection is given on either side of the abdomen. Pasteur is a small, rather spare man, with a much wrinkled, yet kindly face, and grey hair. I was surprised to notice that he has very little power over the left side of his body, and that his speech is affected, so that it is difficult to understand what he says. This condition is the result of a "stroke" he had six years ago. The work of the institution is done by assistants, Pasteur being able to do but little.

The course of bacteriology given in the Institute seems to be very popular, for if one were to put his name on the roll now, it is not probable he could get in before the fall of 1893.

There is much more that might be told of what I have seen and heard, but I have already taken up too much of your space, so I will bring my epistle to a close.

Yours faithfully,

D.J.E.

Reviews and Notices of Books.

A B C of the Swedish System of Educational Gymnastics. A Practical Handbook for School Teachers and the Home. By HARTVIG WISSEN, Instructor of Physical Training in the Public Schools of Boston, Mass.; Instructor of Swedish and German Gymnastics at Harvard University Summer School. With 77 illustrations. Philadelphia and London: F. A. Davis, publisher. 1891.

This book of about one hundred pages deals with the educational department of Swedish gymnastics as adopted in the public schools of Boston, where they now form part of the course.

The author takes up the exercises in groups of a "day's order" after the usual method in the Swedish system. Taking up firstly, *order* for attention; secondly, *leg work*; thirdly, *head movements*; fourthly, *arm movements*; fifthly, *balancing*; and sixthly, *respiratory exercises*. This sequence is followed throughout, the exercises in each group becoming more difficult with the advancement of the pupil. The exercises are explained as clearly as is possible without personal instruction, and it would be a valuable book of reference to any one who is required to teach these movements. The work given is for children ranging from the primary school up to the grammar schools.

R. T. M.

A History of Medical Education from the Most Remote to the Most Recent Times. By DR. THEODOR PUSCHMANN, Public Professor in Ordinary at the University of Vienna. Translated and Edited by EVAN H. HARE, M.A. (Ox.), F.R.C.S. Eng. London: H. K. Lewis. Toronto: J. A. Carveth & Co. 1891.

In the work under consideration we have the first systematic attempt made to give in detail the history of medical education. The history of medicine and medical teaching is so intimately bound up with the history of civilization that the subject is one of great interest not only to the practitioners of medicine, but also to all who take an interest in or have any part in the pro-

gress of education in general. The capital series of papers by Dr. Andrew D. White, now being published in *The Popular Science Monthly*, afford abundant illustration of the great and leading part taken by medicine in general civilization.

Few men are better entitled to undertake the difficult task of giving to the world a history of medical education than the author of this work. For many years he has devoted all his time to this subject, and as professor of the history of medicine in a great medical centre he has had special opportunities of thoroughly investigating the subject.

The first part of the work deals with the history of medical education in ancient times; in India, Egypt, Greece, Rome, etc. In the second part we have an account of medical education in the middle ages. The early influence of Christianity on medical education is entered into very fully. In many respects this was a decidedly injurious influence. The dissection of the human body was no longer allowed, and even the dissection of the bodies of the lower animals was considered to be a work in which no sane man would be found engaged in. The anatomical and physiological writings of Galen formed the sole method by which medical practitioners could make themselves acquainted with these important subjects. In one direction the work of the early Christians contributed to the advancement of a practical knowledge of disease. We refer to the establishment of hospitals where opportunities were afforded to practitioners to become acquainted with the nature of disease and injuries. In spite, however, of these opportunities medicine did not make any advance. Ignorance and superstition were rampant. Sufferers came to the Christian Church, as they formerly did to the temple of Asklepios, to request advice and aid from the priests. Great healing virtues were supposed to reside in the remains of saints and martyrs. Visits were made to their graves with the hope of obtaining relief. Fifteen centuries have passed away and still crowds can be found in various parts of this and the European continent who flock to similar shrines with the same object.

Another very striking similarity between this early period of Christianity and the present age is in the matter of medical

literature of a certain kind. The medical literature of fifteen hundred years ago consisted almost altogether of concise epitomes of knowledge acquired long before. Recently the efforts of many publishing firms, on this continent in particular, have been directed towards the publication of epitomes on all the different branches of medical education. The practitioner of old demanded books of receipts ; the practitioner of to-day buys a book of prescriptions before anything else.

Special chapters are devoted to the history of the development of the methods of teaching the different subjects comprised in the medical curriculum. The first effort made to teach medicine and surgery clinically was at Padua, in the sixteenth century, but the attempt proved a failure. It is to the University of Leyden that the credit is due of placing clinical teaching on a permanent basis. This was in the year 1630. "The method adopted was for the students first of all to examine the patient, then for each one to state his views upon the nature, causes, symptoms, prognosis and treatment of the disease ; and last of all, for the professor to confirm the correct opinion, to confute erroneous ones, and to add any explanation required. But this procedure did not please the students, for they ran the risk of having their ignorance exposed by questions which they could not answer, and Heurne found himself obliged reluctantly to give it up, and in its place to undertake the examination of the patients himself." The Leyden clinic for many years at this period was attended by students from all parts of Europe. The first clinic in the German empire was that conducted by De Haën in Vienna in 1753.

The development of modern medical teaching occupies the greater part of the latter half of the volume. This is mostly confined to the teaching of medicine in Europe. Only a page is devoted to American medicine.

For want of space we are unable to say any more about this extremely interesting volume. The translator's work is well done. The publishers' work is their usual good form.

A Clinical Text-Book of Medical Diagnosis for Physicians and Students. Based on the most Recent Methods of Examination. By OSWALD VIERORDT, M.D., Professor of Medicine at the University of Heidelberg. Authorized Translation from the Second Improved and Enlarged German Edition. With additions by FRANCIS H. STEUART, A.M., M.D., Member of the Medical Society of the County of Kings, New York. With 178 illustrations, many of which are in colours. Philadelphia : W. B. Saunders. 1891.

In spite of the great number of works on medical diagnosis already in the market, we feel confident that Vierordt's will be gladly welcomed by the profession, as it is in many respects much more complete than any other work treating of the same subject that we are acquainted with. It not only presents the subject of physical diagnosis in a very complete manner, but also deals exhaustively with the chemical and bacteriological methods necessary for the formation of a full and complete diagnosis of disease. As chapters deserving special commendation, we would mention those dealing with the digestive apparatus and nervous system. One hundred and thirty pages are devoted to the latter. The illustrations, many of which are coloured, are well executed. Considering the great difficulty of rendering such a work into clear English, the translator has done his work. The American publisher has performed his task in a manner leaving nothing to be desired.

The Principles of Bacteriology. A Practical Manual for Students and Physicians. By A. C. ABBOTT, M.D., First Assistant, Laboratory of Hygiene, University of Pennsylvania, Philadelphia. Philadelphia : Lea Brothers & Co. 1892. (263 pp.)

This book is a very judicious exposition of the methods of bacteriological investigation and the principles which underlie them, and is all the more welcome as it is the first published in America dealing intelligently with the subject. The author's training abroad under the most competent teachers of Germany and the

careful work which he has done in America have eminently qualified him for the task he has just completed. The introductory chapter deals with the salient points in the history of bacteriology, and is followed by chapters on the general biology and morphology of micro-organisms, full descriptions of the methods of sterilization, the preparation of the various culture media, the isolation and study of bacteria, inoculation methods, and post-mortem examinations of animals, concluding with a very useful reference scheme for the completed study of any individual micro-organism. The second part is devoted to the practical application of the methods detailed in the foregoing pages, in the form of laboratory experiments, proceeding from the more simple and fundamental to the more minute and special. These include experiments on the contamination of cultures and on methods of sterilization, with sections on air and water analysis. The more important pathogenic bacteria are then selected for experiment, viz., the organisms of sputum septicæmia, the bacilli of tuberculosis, typhoid fever, diphtheria and anthrax, and the pyogenic organisms. Altogether this part of the work is very suggestive and eminently practical. It is easy to see that the author understands clearly and has constantly in view the difficulties which the laboratory worker will meet at each step in his investigations. The attention to principles and to minutiae of technique which is insisted upon throughout cannot fail to make the student a thoughtful and careful worker in the laboratory. U. A. L.

Essentials of Bacteriology : Being a Concise and Systematic Introduction to the Study of Micro-organisms for the Use of Students and Practitioners. By M. V. BALL, M.D., Assistant in Microscopy, Niagara University, Buffalo, N.Y. (Saunders' Question Compend No. 26.) 1891. Philadelphia : W. B. Saunders.

This book of one hundred and fifty odd pages purports to be "a concise treatise upon the practical bacteriology of *to-day*." The first half is devoted to a consideration of the morphology and biology of bacteria, staining methods, preparation of culture-media, and general bacteriological technique. In this part there is a good description of the general method of staining bacteria,

and a useful list of the principal stains with their composition. No mention is made of the "Arnold steam sterilizer" which is much used in this country and is inexpensive, neither is the very convenient use of ice in solidifying rolled cultures alluded to. The section on the pathogenic properties of bacteria and on immunity are too brief to be of any use. The illustrations of apparatus are fair. The second half of the book is devoted to brief descriptions of the more important pathogenic and non-pathogenic bacteria. With the exception of some coloured plates, the illustrations are poor. Too many species of bacteria are described considering the space allotted to this purpose, with the consequence that the descriptions are meagre and disputed points cannot be given due consideration, a defect which gives an *ex cathedra* tone to this part of the work, and would hence, we think, give to the student the idea that the study of systematic bacteriology was perhaps not such a difficult matter. The book is one of a type to which we have frequently drawn the attention of our readers and which can serve no useful purpose. To the student working in a good laboratory under experienced teachers it is superfluous, and it is impossible to conceive that the practitioner could with its assistance become acquainted with the *principles* of bacteriology, without which practical work in this department of medicine is an impossibility. The author makes a grave admission at the end of the book: "we are conscious of the very superficial manner in which this has been done. We excuse ourselves, however, on the ground that this work is but a wedge with which to enter upon the study, or, for those who do not care to proceed further, an eminence from which a fair view of the ground can be obtained." Why work with poor tools: and of what value is superficial knowledge? H. A. L.

Notes on the Examination of the Sputum, Vomit, Fæces, Urine and Blood. By SIDNEY COUPLAND, M.D., F.R.C.P., Physician to the Middlesex Hospital, and Lecturer on Practical Medicine in the Medical School. Second edition. London: H. K. Lewis. 1891.

This little volume is valuable to practitioners and clinical clerks. It gives a good account of the chemical, microscopical and bac-

teriological examinations necessary for the diagnosis of disease. The work is one which we can confidently recommend, and as it costs only thirty-five cents, it should be in the hands of every one who is desirous of keeping up to the most recent methods of clinical investigation.

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Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 18th, 1891.

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

Sarcoma of the Testicle.—DR. LAFLEUR exhibited the specimen of a testicle uniformly enlarged, surface smooth, and tunica thickened. On cutting it open some soft substance bulged beyond the tunica. On section, the thickened tunica is seen with a new growth, consisting of sharply circumscribed areas of a dull yellow colour, while a grumous material filled up the spaces between these areas. Microscopically it is a round-celled growth, the cells being a little smaller in size than leucocytes, and have deeply-staining nuclei. Mixed in with the fibrillated substance there are spindle-shaped cells with oval nuclei. The yellow areas consist of necrotic tissue, are structureless, and do not take the stains. The softer portions consist of a broken-down mass of detritus with cells here and there that will take the stain. He could give no history of the case, but from the appearance of the testicle the disease was probably of very rapid growth.

Cancer of the Lower Jaw.—DR. HINGSTON exhibited two lower maxillæ which illustrated the two modes of invasion of the disease. In the first case the disease had begun in the bone.

itself, and in which the loss of substance was about the size of a finger, and had slightly involved the submaxillary gland. In the second case the disease had appeared on the outer surface of the bone as a result of extension from secondary disease of the submaxillary gland, a cancer of the lip having been removed a year before. When the disease begins in the bone itself the patient has a very much greater chance of recovery than when it is due to extension from the gland. He thought that he had better results after the operation for removal of the jaw for cancer in well chosen cases than he had after removal of the breast. In one case he had removed the upper jaw and there was no return. In another case where he had removed the upper jaw the patient died of old age. It is necessary to make a clean sweep of all the diseased parts to have a satisfactory result.

Dislocation of the Astragalus.—DR. HINGSTON exhibited a specimen and related the history of a complete enucleation of the astragalus. The patient, a powerful young man, got his foot caught in a strap in close proximity to a circular saw, and on making a very violent effort to escape produced this peculiar condition. There was a large projection on the inner side of the foot, over which the skin was very much torn, and by simply enlarging the incision and with the aid of the bone forceps the astragalus was removed. There was also rupture of the tendo-Achillis, but the malleoli and the other bones of the tarsus were uninjured.

Enlarged Spleen.—DR. HINGSTON related the history of a woman from whom he had, two weeks previous, removed the spleen, which weighed 13 lbs. The organ extended down into the pelvis and in front beyond the middle line, and had been of slow growth. The operation had been performed at the urgent request of the patient, and Dr. Hingston did not think that it was an operation he would care to repeat. After separating the connections with the stomach and liver he came down on the pedicle, which was found to be very short, it being necessary to encroach on the substance of the spleen before a sufficient hold could be obtained on the vessels to cut them, the pedicle that

was removed with the spleen being only three-quarters of an inch in length, consisting of the remains of the splenic artery one-quarter of an inch and the celiac axis half an inch. The substance was very friable and was easily torn, consequently hemorrhage was very great. The patient died seven hours after the operation. The removal of the spleen when there is an impoverished condition of the blood, when the white corpuscles are in excess, is not a successful operation.

DR. SHEPHERD did not think that primary cancer of the lower jaw was common. When a growth started about a tooth it was usually an epulis. He had removed many jaws, but had only one that did not recur, and asked if a microscopical examination had confirmed the diagnosis of cancer. He agreed with Dr. Hingston in regard to the bad prognosis in cases like the second. He had had three cases of removal of the astragalus for dislocation; in one case the man had a compound fracture of the opposite leg to the one in which the dislocation occurred, the result being an equal shortening of both legs. The spleen usually has a very long pedicle. He cited a case of removal of the spleen performed by Dr. Roddick in 1885 for severe laceration, part of the injured organ protruding through a wound. The patient died several hours after, when it was found that both the liver and kidneys were ruptured.

DR. HINGSTON, in reply, said that a microscopic examination had confirmed the diagnosis of cancer. As a surgeon, he would rather trust to his sense of sight and touch, even if such an examination was not confirmatory.

DR. LAFLEUR cited a case in which the tongue had been removed for supposed cancer, which on microscopic examination proved to be tuberculosis, and the patient died two weeks after the operation with acute miliary tuberculosis.

Nephro-Lithotomy.—DR. SHEPHERD exhibited a large *branched kidney calculus* which he had removed a week before from a lady aged 50. She had suffered from symptoms of stone in the kidney for some thirteen years, and recently, after an attack of renal colic, a tumour developed in left loin and pus ceased to appear in the urine. The temperature ranged from 101° to 105°, with

rigors and sweatings. On cutting down in the left loin the kidney was found perfectly movable. When incised a large amount of pus escaped, and on introducing the finger a branched calculus was felt in the pelvis of the organ and with difficulty extracted, as some of the branches breaking off remained encysted and were very hard to enucleate. The kidney was very much disorganized, and was of large size. The patient, at the time the report was made, was doing very well, and the temperature was perfectly normal. Dr. Shepherd remarked that he had previously removed the kidney for a similar condition, but now he preferred to remove all the stone, break open all pus pockets, and then drain freely. In this way what remains of the kidney substance continues to do its work, and the patient's chances are so much the better in the future in case the other kidney becomes similarly affected. In addition to this reason, he stated that nephro-lithotomy was a much less dangerous operation than nephrectomy. Dr. Shepherd related a case where he had removed one kidney for calculous pyelitis, and four years after the other kidney became disorganized from the presence of a calculus. Operation was refused because patient had only one kidney, and she died uræmic a few days after entering hospital.

Placenta Prævia.—DR. SPRINGLE gave the history of the case. (See page 572.)

Two Cases of Nephro-Lithotomy.—DR. SPRINGLE exhibited the calculi and gave the histories of the cases, which will appear in our next number.

DR. SHEPHERD congratulated Dr. Springle on his diagnosis. He had on several occasions cut down on the kidney for pain and found nothing, but at a subsequent operation he discovered a stone. In the case where pus still continues to be present in the urine, he thought that some fragments of stone must still be present in the kidney, and advised further exploration.

DR. ARMSTRONG said that cutting into a healthy kidney was a new operation; that the diagnosis is often difficult, and failure to find the stone does not indicate an error of diagnosis, for it may be discovered at a subsequent operation.

Stated Meeting, January 8th, 1892.

F. BULLER, M.D., PRESIDENT, IN THE CHAIR.

Anatomical Anomalies.—DR. SHEPHERD exhibited the following:—

(1) A case of *Persistence of the Right Aortic Root* in a female. In this case the right subclavian artery arose from the descending arch of the aorta and passed up to the first rib behind the trachea and œsophagus. The fourth arch having disappeared, there was no recurrence of the inferior laryngeal nerve round the subclavian. The nerve passed directly to the larynx.

(2) A *Skull*, in which there was a well-marked *par-occipital process* on each side of the occipital bone. This condition is normal in many carnivorous and graminivorous animals, but is of rare occurrence in man. This process is the homologue of the transverse process of the vertebræ, and usually exists as the jugular process.

(3) A *Sternum* with well-marked *ossa suprasternalis* united by ligaments to the sternum and covered with cartilage. These bones are vestiges of the episternal bones of monotremes and lizards, and are of great rarity in man, this being the first specimen Dr. Shepherd had seen. It is supposed by morphologists that the meniscus seen in the sterno-clavicular articulation represents a remnant of this bone.

(4) A case in which there were large patches of *calcification on the dura mater*. No history.

(5) A case of *Rheumatoid Arthritis* involving the joint between the odontoid process of the axis and the anterior arch of the atlas. A large mass of bone is thrown out around this process from the anterior arch of atlas, forming a cap for the upper end of the odontoid. No history.

Lymphatic Leukæmia.—DR. LAFLEUR exhibited specimens of glands from a woman aged 50, who had suffered from rapid anæmia and glandular enlargement in the neck; no positive diagnosis had been arrived at before death. At the autopsy, on opening the abdomen the spleen was seen projecting three inches below the costal margin, and it measured about thirteen inches

in length, six or seven in breadth, and four in thickness; was soft and the pulp diffuent; the colour was normal, and no growth was found in its substance. The glands all over the body were enlarged, and were similar in all the situations. They were isolated, smooth, and rather soft. On section, they were of a pinkish-red colour, while a number showed ecchymoses. From the medullary spaces of the sternum and ribs a light reddish semi-fluid material could be compressed. There was no opportunity of examining the marrow of the other bones. No other notable changes were observed. The liver was normal in size; there were no lymphoid nodules. The kidneys were slightly hyperæmic. No examination of the blood had been made before death, and the blood obtained at the autopsy was disorganised; all that could be made out was a moderate increase of white cells. In the pharynx the lymphoid structures were swollen; the lingual tonsil and tonsils stood out as prominent white tumours, and were ulcerated on the opposing surfaces. In both the glands and spleen there was simple hyperplasia of the lymphoid cells. The question arose, Under what head should this condition be diagnosed? Lymphatic leukæmia, rapidly-growing sarcoma, or Hodgkin's disease? As the condition of the blood was not known it is difficult to make a positive diagnosis. The characters and enlargement of the glands are like those seen in Hodgkin's disease, yet there were no lymphomatous nodules present in the spleen.

DR. SCHMIDT, who had attended the case, said that he had been called to see the patient about eight days before death. She was a widow, aged 62 years, and for two months had been suffering from symptoms referable to the stomach, vomiting and pain. He found her in bed suffering from weakness and dyspnoea, with expression of much suffering; dry, sallow skin, and unable to lie on the right side on account of the pain produced in the left. Liquid food only could be taken. A tumour was felt in the epigastric region extending from under the ribs to almost the level of the umbilicus, and was tender to the touch. The right leg was much swollen. A few days before death a sore throat was noticed, which was, to all appearances, of the nature

of diphtheria. The tonsils were covered with a thick yellowish-white membrane, and here and there on the mouth were small white patches, probably of an aphthous nature. Only one record of the temperature and pulse had been taken, and that a day before death, the temperature being 99.4° and pulse 108. At this time she passed a black stool mixed with some bright blood. Glandular enlargement in the neck was only noticed two days before death. From the general appearances, Dr. Schmidt thought that it was probably a case of cancer of the stomach.

Ulcerative Endocarditis.—DR. LAFLEUR exhibited a very typical specimen of this condition. The patient, a negro, aged 40, had an attack of rheumatism (the first attack) six months before, and had been in the hospital for three months. Clinically there could be detected signs of an endocarditis with insufficiency of both aortic and mitral valves. At the autopsy there was found hypertrophy and dilatation of both ventricles and left auricle, the hypertrophy about compensating dilatation. There was old disease on the mitral valve, while on the ventral flap was a large vegetation, having a hole in the centre, and to it was attached a large fibrinous clot, which was divided into threads at the end, caused by its flapping backwards and forwards in the blood-stream. There is an erosion and rupture of the tendinous cords attached to one of the papillary muscles, which is very characteristic of malignant endocarditis. There is general thickening of the aortic valves, with vegetations where the valves touch each other. There is a distinct loss of substance, which is encircled by a rim of vegetations. There were no septic emboli found in any part of the body. This is rather unusual, as the proportion of non-embolic to embolic cases is small. Other lesions in the body were those of chronic heart disease. The immediate cause of death was a lobular pneumonia.

DR. MILLS asked if the pneumonia could be traced to the condition of the heart.

The PRESIDENT said that it is not an infrequent occurrence to come across an embolus of the central artery of the retina, and he could not think that this vessel could be the only one singled out. He had seen cases which had been so diagnosed

when no changes could be found in the heart or vessels, and thought if the diagnosis was correct there must be some further explanation of the occurrence of these emboli.

DR. LAFLEUR, in reply to Dr. Mills, said that there was no evidence connecting the pneumonia with the heart lesion. In answer to Dr. Buller, he said that the only explanation he could give was that the ophthalmologist takes much greater notice of minutiae than the general practitioner. There may be many emboli all over the body which could not be diagnosed except by such direct examination as by the use of the ophthalmoscope.

Multilocular Ovarian Cyst containing Bone and Cartilage.—

DR. E. A. MCGANNON of Brockville exhibited the specimens, which he had removed from a girl of 16 on Dec. 30th, 1891, and gave the following history of the case:

The patient had always been healthy, though somewhat anæmic for the last two years. Menstruation began at 14½ years, had always been regular and of the twenty-eight day type, flow lasting for three days, being scanty and without pain. She first came under my notice complaining of lancinating pains in the left inguinal region. On examination, an abdominal tumour was found, which I diagnosed as ovarian. Consent was withheld until a short time previous to the date of the operation. The patient was then put into the St. Vincent de Paul Hospital and subjected to the usual preparation for abdominal section. On Dec. 30th, assisted by Drs. M. C. McGannon, T. F. Robertson and J. W. Lane, I opened the abdomen and removed the specimens now presented. The pedicles were ligated with silk and the stumps carefully covered with peritoneum, catgut being used in this procedure, and then dropped. The abdominal wall, as a whole, was taken up by silkworm gut sutures, but before tying them each layer of the wall was brought together with catgut. The patient made an uninterrupted recovery, the temperature reaching on one day only 99½°.

I must ask your pardon for thus going into some of the details of this operation when presenting a specimen; but I desire to invite discussion on some points of interest other than those presented by the specimen. First as to the specimen. The larger

of these tumours was taken from the right side, and, as you see, is a mixed tumour, being a multilocular cyst containing cartilage and bone—a rather rare variety of tumour, and one that I believe occurs oftenest in women of from 15 to 25 years. The smaller tumour, taken from the left side, is simply a cystic ovary showing well the marks of ovulation. This patient began to menstruate only eighteen months ago, yet these ovaries have been active and these tumours have been developing much longer than eighteen months, which is, in my opinion, strong evidence in support of the theory that ovulation has little to do with menstruation, and goes on long before that function is established. Second, I would invite criticism on the utility of carefully covering the stumps with peritoneum, thereby avoiding adhesions. Third, as to the closing of the abdominal wound. Hernia following laparotomy or abdominal section is, unfortunately, not rare, and is a very embarrassing sequela. It is no doubt frequently, if not always, due to some particles of fat or muscle getting between the fibrous layers of the abdominal wall and preventing their union. Primary union may occur in the skin, but the skin is an elastic tissue and plays no part in supporting or keeping *in situ* the abdominal contents. It is very essential that good union should be had between the fibrous layers, and to this end they should be brought together. The time is coming, if it has not already arrived, when hernia following abdominal section will be charged (and properly so) against the operator who neglects to thus close the abdominal wall. The sutures through the whole act as supports or splints, and though silkworm gut is efficient, silver wire, in my estimation, would be better.

DR. WM. GARDNER considered the specimen of great interest, as such a condition is very rare. There is nothing of the dermoid nature about it. He had removed many dermoids, but had never come across a cyst containing bone and cartilage. It is very generally admitted that menstruation may exist independently of ovulation; the persistence of menstruation after the removal of the ovaries may be accounted for by some portion of the ovarian stroma being left behind at the time of the operation, or that ovarian stroma may have existed in some other situation

as between the layers of the broad ligaments. It often, unhappily, occurs that menstruation and pain are not relieved by the removal of the ovaries. Regular menstrual discharge also persists in double ovarian tumours, due, probably, to some of the stroma remaining unaffected. In regard to the technique suggested, he thought it a very complicated method. In his experience hernia is exceedingly rare, and he had never taken such precautions. Mr. Tait, in a lecture which appeared in a recent number of the *London Lancet* (Sept. 12, 1891), laid great emphasis on *not* making the incision in the linea alba, but on opening the sheath of one of the recti muscles, and by this procedure claimed that the danger of hernia is lessened. He (Dr. Gardner) simply repeated the statement, but was not able to confirm it. If a splint was needed for the abdominal incision, he thought silkworm gut was infinitely superior to catgut, as it could be buried and would be permanent. Speaking of catgut as a material for ligatures, he said that he had, during the last few months, used a large quantity of it, and it had never showed any evidence of setting up trouble. He had much more confidence in it now than formerly, and in plastic operations on the vagina nothing was equal to it.

DR. MILLS said that in the lower animals, what corresponded to menstruation is always associated with ovulation, and he thought that as the process of civilization had produced disturbances of the menstrual function, so there may also be a more or less dislocation of the two processes. Again, as the genital organs constitute a complex whole governed by a complex nervous mechanism, there may be other influences that tend to bring about menstruation independent of the reflex action from the ovaries. Periodicity may also account for the appearance of menstruation after the removal of the ovaries.

DR. SHEPHERD thought that the tumour was congenital; it was something like a tumour he had seen in the floor of the mouth. As for closing the abdominal wound with buried sutures, it was very good in theory, but he did not know if it had been proved that hernia never occurred after such a proceeding. He had had only one case of hernia following abdominal section, and

that was in a case where there was a large stinking abscess about the appendix, which was plugged with gauze and allowed to heal by granulations. In using catgut, he never felt sure that it was aseptic. He preferred the finest silk for buried sutures, and thought that it was the safest material that could be used.

Stated Meeting, January 22nd, 1892.

WESLEY MILLS, M.D., IN THE CHAIR.

Carcinoma of the Ovary.—DR. ALLOWAY exhibited the specimens and gave a detailed account of the case, which appears on page 561.

DR. LAPHORN SMITH congratulated Dr. Alloway on his presence of mind. He said that it was formerly the custom to apply a tight binder about the abdomen to prevent the blood flowing into the large abdominal veins after the pressure of the fluid or the tumour had been removed, and thus increased the pressure in the coronary arteries. He thought that the salt solution in this case acted in the same way.

DR. W. GARDNER could not explain why collapse had come on so long after the operation. He asked why Dr. Alloway had used such a strong salt solution; that which he was accustomed to use was very much weaker. He noticed that the ovaries were very small for this condition, and asked Dr. Alloway if he thought that the disease was primary in the ovaries, with secondary deposits in the omentum and retro-peritoneal glands. He had had a number of cases of carcinoma of the ovary with ascites, but always found the organs markedly enlarged.

DR. ALLOWAY replied that he thought the disease was primary in the ovaries; he could give no reason for their being small. The disease appears in both ovaries nearly twice as often as in one. The only explanation he could give for the syncope not occurring at the time of the operation was the stimulating effect of the ether, and when that passed off the diaphragm dropped and removed support from the vessels, and the patient was literally bleeding to death within her own veins. In carcinoma the

ascitic fluid is poured out and is not absorbed, because the lymphatics are blocked.

DR. J. E. MOLSON asked how, then, was the salt solution absorbed?

DR. ALLOWAY said that the salt solution was much more absorbent than the grumous ascitic fluid.

DR. MILLS was glad Dr. Alloway did not explain the absorption of the salt solution on the theory of osmosis; he had always opposed this theory, and thought that before very long it would disappear from physiology. Would the saline fluid be so rapidly absorbed as to raise the blood-pressure and to cause the heart to act so much better? He rather favoured the view that the warmth acted as a stimulant to the nervous system, for in experimenting on frogs' hearts, if, after the heart has ceased to beat, salt solution is run through it, it will be stimulated into activity. The stimulating effect of the warm bath is familiar to all. He thought that sterilized water would have acted in a similar manner. He looked upon the ascitic fluid as an excretion, and being such could not be absorbed again.

Ovarian Cyst and Chronic Salpingitis.—DR. A. L. SMITH exhibited the specimens and read the following report of the case:—

Mrs. B., aged 41, was sent into the Woman's Hospital by Dr. England. She came under my care there on January 1, 1892. She was a tall, rather thin, but wiry-looking woman, and bore on her face the traces of prolonged suffering. She was married, the mother of six children, and had her last child six years ago. She had no miscarriages. Menstruation had been normal as a girl; since marriage it had been normal, but for the last six years it has been exceedingly painful, irregular, and profuse. She enjoyed fairly good health until three years ago, when she was taken ill with inflammation of the bowels (pelvic peritonitis), which confined her to bed for seven weeks, five of which were in hospital. She has never been a day well since. Locomotion has been painful, and there has been unbearable dyspareunia. She was unable to work, and had to spend the most of her time in bed or lying around. On examination, the cervix was found

to be lacerated and hypertrophied, but slightly movable; the fundus was firmly fixed. Just above the cervix, in Douglas' pouch, there was a sharp angle, into which the finger tip could be introduced, and above that a large, round, sensitive swelling which felt like a retroflexed fundus. Pressure on this caused a sickening sensation and the sound entered the uterus forwards. All above and on both sides of the uterus the pelvis was filled with a hard mass which could not be moved. Diagnosis before operation was, therefore, pyosalpinx with local peritonitic effusion binding down the ovaries and tubes in Douglas' cul-de-sac.

Operation.—After several days of preparatory treatment—hot baths, purgatives, hot douches and dieting—the patient was anaesthetised with the A.C.E. mixture at 12.30 on the 9th Jan. Dr. England assisted me, and there were present Drs. Campbell, Reddy, Bruère, and the members of my class. The abdomen was shaved and scrubbed with soap and water and bichloride. A three-inch incision was made in the median line, and on introducing two fingers of my left hand into the abdomen I found the true pelvis walled off from the rest of the abdominal cavity by a false membrane, which I had to go through in order to reach the uterus on the left side. My finger then came upon a fluctuating sac about the size of a small orange which was continuous with the tube. With the greatest difficulty I managed to dig this out of the mass of adhesions in which it was buried, which I had to dissect with my finger until I reached the bottom of Douglas' pouch. The cyst proved to be the ovary with the tube enlarged and adherent to it. On the right side, deep down, I dug out without much difficulty what proved to be a coil of small intestine. On trying again I brought up the very much thickened right tube, which I ligated and cut off. The right ovary seemed normal, and I therefore left it. The cut ends of both tubes were touched with Paquelin's cautery. The peritoneal cavity was then flushed with a gallon or two of boiled water at 110°F. until it came fairly clear; some of this water was left in. A long glass drainage-tube, open at both ends and perforated on the sides, was introduced to the bottom of Douglas' pouch, and the abdominal incision was closed with six silkworm gut sutures

passed through the entire wall three-quarters of an inch from the edge. The drainage tube was fastened to the nearest of these stitches and filled with a strip or wick of sterilized gauze. The wound was then buried in a thick layer of boracic acid and a dressing of gauze placed over it, the drainage tube being closed with absorbent cotton. The vomiting after the operation was very severe, and persisted for several days. The tube was removed at the end of forty-eight hours, and was found to be full of coagulated bloody lymph which the wick had failed to aspirate. Efforts were made to move the bowels with Rochelle salts at the end of twenty-four hours, and were repeated every four hours for two days before anything passed through. A great many things were tried to stop the vomiting, but what succeeded best was one grain of calomel and five grains of bicarbonate of soda every hour. A turpentine enema and turpentine stupes brought away the first wind and promptly reduced the commencing tympanitis. I allowed her one small hypodermic of Battley immediately after the operation, and the house surgeon gave her another the second night. After that the pain was relieved with hot fomentations, which were very effective. The temperature has been $98\frac{1}{2}^{\circ}$ most of the time, except on the evening of the fourth day, when it rose to $101\frac{1}{2}$, and two or three other times when it reached $100\frac{1}{2}^{\circ}$. This is now the fourteenth day and there is every prospect of her recovery from the operation.

DR. A. BRUERE gave the following report of the microscopical examination: The transverse sections of the tube reveal rounded-celled infiltration of the fibrous connective tissue of the mucosa. In many of the folds of the mucous membrane these cells have undergone fatty degeneration, and fat globules and detritus are to be seen. The ciliated epithelial cells lining the mucous membrane have undergone proliferation in some places. Several layers of non-ciliated epithelial cells, irregular in shape, are to be seen. Between the circular and longitudinal layers of the muscular coat the fibrous tissue is more dense than normal, but there does not seem to be any atrophy of the muscular elements. In the serous coat most of the small veins and capillaries are distended with blood, and there are also extravasations of blood.

A large number of small round cells are to be seen in some parts of the fibrous tissue. Dr. Bruère showed several of the sections under the microscope.

DR. ALLOWAY asked Dr. Smith why he removed the right tube and not the right ovary. The object of the operation was to bring about the menopause.

DR. WM. GARDNER also thought that the ovary should have been removed. He did not think that the menopause would occur. He said that he had repeatedly found blood-clot in the drainage tube, and he preferred the sucking method of cleansing it. There is a decided reaction going on against the drainage tube. Howard Kelly had not used it in his last forty cases, as he had learned to trust more to the power of absorption possessed by the peritoneum. If the use of the drainage tube can be avoided the patient will be in a much safer condition, for it is a source of danger, being liable to become infected. Abdominal surgery of the present day without the drainage tube is not what it was ten years ago without the drainage tube, for we have learned that if the peritoneum is aseptic it may be trusted to absorb any blood that may escape into it.

DR. SMITH, in reply, said from his experiences in a former case, where the character of the woman towards her husband had been entirely changed by the removal of the ovaries, he thought that by leaving the ovary or even a portion of one there would be enough to keep up the physical traits of sex, and he hoped that by so doing in this case the pelvic symptoms would be relieved and her character would remain unchanged.

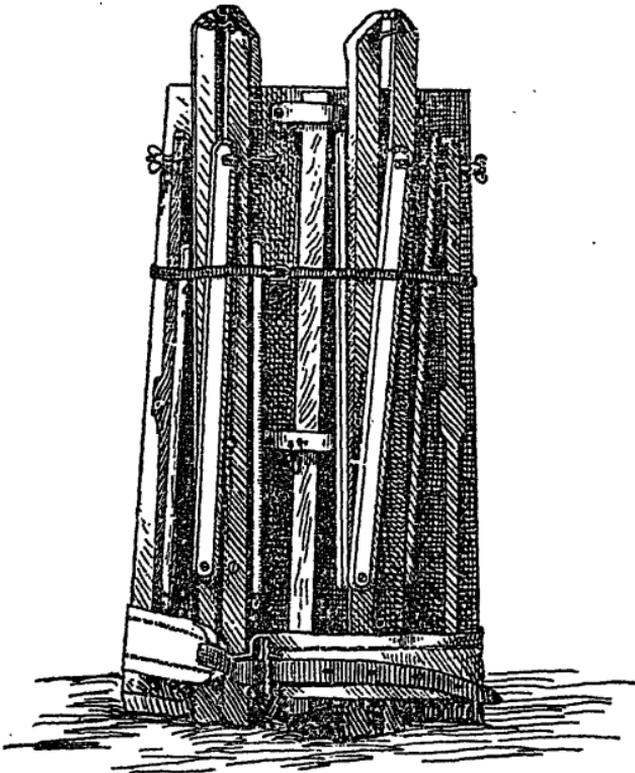
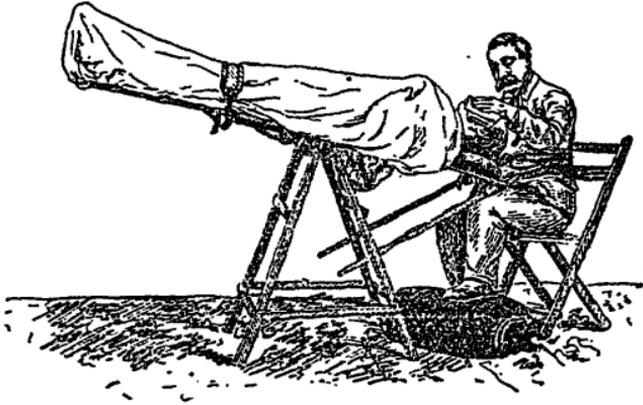
DR. ALLOWAY said that it is a well known fact that the removal of the ovaries has nothing more to do with the change of character than is seen in a woman years after the menopause.

DR. MILLS thought the question was of great importance. It should be definitely settled whether a surgical operation modifies the function or not. Castration changes the nature of a dog very much more than the removal of the ovaries affects a bitch, and he regards it as an illegitimate procedure.

A New Portable Laparotomy Table.—DR. LAPHORN SMITH exhibited a table of his own invention. He said that when a

surgeon is suddenly called upon to perform laparotomy in a private house, the first requirement is a *clean, narrow* table, and this is seldom available. He thought it was desirable for the laparotomist to bring his own table with him. Such a table must be of so small a compass that it can be placed in a carriage, and though strong enough for its purpose, should be light in weight, and should not be expensive. As certain steps of the operation are to be performed in the horizontal position and others in the Trendelenburg position, it is necessary that this table be so constructed that the change in position can be readily made. The table, which he showed, possesses all these requirements. It is made of a pine ironing board, one inch thick, cut in the middle, and hinged so as to fold up, measuring six feet long when open and three feet when closed. It is 18 inches wide at the top and tapers down to 12 inches at the bottom. A sliding bar three feet long, made of hard wood, gives increased strength at the joint. The legs are made of inch and a half pine, and can be folded up; when opened out they form a sort of wooden horse, three feet high, on which the table is balanced on a pinion, like a pair of scales, so that the head can be raised or lowered with the slightest pressure. Two iron bolts fasten the top of the table to the legs, and are provided with thumbscrews, which can be tightened up in a moment. The table is prevented from teeter-tautering by means of two folding bars fastened at one end to the head of the table, the other end passing through a notch in legs, where they are fixed in any position by steel pins passing through them. The legs are stayed with folding bars, one end being provided with a slot which passes over a screw head in the leg opposite to the one to which it is attached. As to strength, the table had been several times tested with persons weighing over 200 lbs. lying upon it. As to lightness, it weighs altogether only 30 lbs. It folds up so small that it may be easily carried in the hand or under the arm. It is provided with a strap of broad webbing which not only serves to bind the legs and the table together when being carried, but also to fasten the patient securely to the table. The greatest claim to originality is the *low cost*. Cleveland, Edebohls, Trendelenburg and Fœrster

have each invented tables, but they are not only too heavy and bulky to be portable, being made of iron, but they are exceedingly expensive, costing from \$35 to \$150. With this description and the accompanying engravings any carpenter can make



the table for about \$5. Therefore its cheapness is as valuable a quality as its comparatively great strength and portability.

Friedreich's Disease.—DR. SCHMIDT regretted that he had not been able to obtain permission to bring the patient, an inmate of St. Bridget's Home, before the Society, but gave the following history of the case :—The patient, a girl of 21, suffers from a train of nervous symptoms. Her mother died fourteen years ago, having been paralyzed for some time ; father died three years ago of influenza ; one sister is affected in the same way as the patient, and is at present confined to bed ; a female cousin cannot walk, and has clonic contractions of the face and hands ; and one brother died of consumption. She first noticed difficulty in walking nine years ago. She now walks with great difficulty, the gait being very ataxic, feet wide apart ; the whole foot touches the ground at the same time. She looks continually on the ground, the body being bent forwards. Movement of the hands and arms also ataxic. Speech is scanning and is difficult to understand. Tremulous movements of the tongue when protruded. Slight nystagmus, but no other eye symptom discovered ; pupils dilated. She can stand alone with the eyes closed, though vacillating ; when sitting she moves continuously. Sensibility of the skin unaffected. Sometimes has pains in the hands, but pain along the spine is almost constant. There is a slight left lateral curvature of the dorsal region of the spine, the hollow of the lumbar region almost obliterated. There is loss of patellar tendon reflex ; no ankle clonus. She sleeps well and her mental condition is good.

Selections.

AN ADDRESS ON SOME OF THE MORE UNUSUAL PHENOMENA OF EPILEPSY.*

By S. WILKS, M.D., F.R.S.,
Consulting Physician to Guy's Hospital.

I need scarcely remark how unsystematic is our nomenclature of disease. Some diseases have for their appellations an anatomical basis, whilst others are named after a group of symptoms, or, rather, after the most prominent of the symptoms. This method is more satisfactory than the other, as it does not tie us to any pathological fact from which there is never afterwards any escape. If we see a combination of symptoms, which is repeated over and over again in different persons, we are warranted in giving a distinct appellation to that group. Having done this, we ask ourselves, Are we bound to require the presence of every one of those symptoms to constitute the disease? We say no; but then comes the more difficult question, Which are the essential ones? Take, for example, exophthalmic goitre? we have all agreed to give this name in any particular case, even if the eye is not affected, the other symptoms of the disease being present. We have also agreed to do the same, under like circumstances, even if the thyroid be unaffected. I myself go further than this, and believe I see the same affection when neither throat nor eye is involved, so that we have in fact the play of *Hamlet* without Hamlet. When I see, for example, a patient much wasted, with very quick pulse, sweating, etc., and relieved by the same remedies which cure Graves's disease, I believe I have pathologically this complaint to deal with.

Now, as regards epilepsy. No disease is more characteristic in its typical form—that is, where a person falls down with a loss of consciousness, followed by convulsions, and terminating in a deep sleep. One of our latest writers, and I should also say in this (Guy's) hospital, a great authority—I mean Dr. Frederick Taylor, in his *Manual of Medicine*—still keeps to the definition.

* Read at a meeting of the South London District of the Metropolitan Counties Branch of the British Medical Association.

There is no doubt that as a definition, and applicable to the majority of cases, this is good ; but when one takes in the whole field of possible examples of the disease we find a difficulty in so restricting the name. That the definition is generally good is seen from the fact that where a local lesion is found in the brain, which is not the case in ordinary epilepsy, there may be no loss of consciousness during the fit. So it may be said we have a different disease to deal with. And yet it is this very case which prevents us adopting the definition ; for even should there be a local disease, as a gumma, it not infrequently happens that the convulsions are general, and the unconsciousness is complete. It would therefore be difficult to separate two cases, because the symptoms vary when the anatomical basis is the same in both. I believe, therefore, the highest authorities would not deny the use of the term epilepsy, even if the convulsion were partial, and no loss of consciousness occurred, The loss of consciousness has always been considered the most important symptom of the two, and all writers have included the *petit mal*—the case where there is a sudden loss of consciousness and no other symptom—under true epilepsy. So that, as in exophthalmic goitre, both symptoms which are often said to characterise the disease may be absent. We may have epilepsy, though there may be respectively no loss of consciousness or no convulsion. We shall presently ask whether both of these may be absent in the same case, and yet we be warranted in calling it epilepsy.

A great deal of what I say has long been admitted, since in undoubted epileptics we witness attacks where nothing more is present than a strange feeling in the limbs or a sudden pain in some part of the body ; in others an aberration of the senses or perturbation of an important organ, and sometimes only a strange mental disturbance. Now any of these phenomena may constitute the main feature in the case, and if they occur where there is a history of any attack of the graver form we have no difficulty in interpreting the symptoms and giving the name epilepsy. Frequently, however, patients come to us without any such history, and if they are unaccompanied by relatives or friends we have no corroborative evidence of the correctness of the tale,

and we find ourselves in a difficulty in pronouncing upon the nature of the case.

I need scarcely allude to instances with which every medical man is familiar, where the aura constitutes the main symptom, or, at least, is that of which the patient has most knowledge. Some curious cases of this sort have come before my notice. A little girl was said to have occasional stabbing pains in her head, coming on at intervals and without warning, and in consequence she was thought to have some serious disease of the brain. Whilst sitting in a chair by my side she suddenly called out with pain in her head, and fell back unconscious with convulsive movements of the face and other symptoms of epilepsy.

Dr. Sutton related a case where a man was treated for angina pectoris owing to a sudden pain occurring in the chest. When carefully watched he was seen to be an epileptic. A middle-aged man came to me complaining of sudden attacks of sickness; when his wife subsequently called on me and described other symptoms, it was clear that the vomiting was the onset of a mild epileptic attack. A very curious case was sent me of a young man whom the doctor was treating for syphilitic symptoms; he was said to have a syphilitic sore on the tongue, which, strangely enough, every two or three weeks broke out bleeding in the night, which woke the patient. What he really was suffering from were epileptic seizures in the night in which he bit his tongue. A clergyman came to me saying he had sudden loss of sight. Whilst reading the service in church this would momentarily occur, but it immediately passed off, and he would continue reading. On close questioning, he would not admit the existence of any other symptom. I subsequently heard that he had had two most violent epileptic fits.

Then, again, the aberration or confusion of mind is well known. I had an epileptic friend who would become confused as he walked along the street, and then perhaps fall down. At other times he would continue walking, and behave so strangely that the police would have to take charge of him. In this condition the patient may be guilty of violence or do some eccentric act, as in the case of a young man who some years ago shot a girl

without any reason. He said afterwards that he was quite unaware of what he had done, and, as corroborating his statement, he had a fit in the course of his trial. Another patient was driving out in his gig as usual when he went in the wrong direction, and then continued driving about without aim or object until the boy who was with him started him home. The boy gave a description of his master's eccentric conduct; the latter knew nothing of it.

Simple falling, as in *petit mal*, might be syncope, but in both cases it is probably due to sudden diminution of blood in the brain. If the brain be for a moment deprived of its proper allowance of blood, unconsciousness occurs and the patient falls; this was shown by Sir A. Cooper in animals on ligaturing the cerebral vessels. In those cases where the whole brain suffers from diminished circulation, loss of consciousness occurs with paralysis of the whole body. In like manner, should a part of the brain be deprived of blood, there would be a temporary paralysis of the part of the body which it rules over, but no loss of consciousness. The first case is seen in the *petit mal*, where a patient will become suddenly unconscious, and as rapidly recover. In that form of complaint known as Jacksonian epilepsy, where in a fit one side may be convulsed, but where there is no loss of consciousness, we believe part of the motor region is involved, and generally by a gumma. In this case we often find the convulsed limb remain for some time weak. Now we have only to suppose that this portion suddenly loses its function as does the whole brain in the *petit mal*, and we have the case of a sudden loss of power in the limb without convulsions. In these local affections we may have indeed a strange feeling, a convulsion and loss of power in succession, or have each separately. The truth of this proposition is proved by patients who tell us they have strange feelings in a limb, or movements coming on at intervals and without warning, and whom we know to be true epileptics. For example, a young woman, aged 25, has had several epileptic fits, in which she was convulsed, bit her tongue, etc. This was preceded by a pain in the left foot, running up to the knee. She was put on the bromide and the fits ceased,

but subsequently she had repeated attacks of pain in the leg, but these did not culminate in a fit. A girl, aged 15, had had several well marked epileptic fits; before they came on she frequently called out from pain in the left arm and leg. Besides these bad attacks she often had the pain and strange feelings in the arm and leg, but followed by nothing more. I know a young man who has had slight epileptic attacks preceded by an aura in the right arm. Sometimes as he walks in the street he feels this sensation in the arm and throws it about, and by force of will avoids an attack. This is quite on a par with drawing a tight ligature around the arm and arresting a seizure.

Knowing all this, ought we to put in the category of epilepsy cases which come before us where no other than local symptoms such as these have occurred? Sometimes we prove we are perfectly justified in so doing by the subsequent event. A young man came to me saying he had violent attacks of shaking of his head coming on every few days. A medical man who knew him well said he had no other symptoms, but I believed they were epileptic in nature. I subsequently heard that he had had attacks of unconsciousness.

A middle-aged man came to me saying that for nearly two years he had been subject to strange feelings in his left arm and back of neck. He felt inclined to fall, but did not. I put epilepsy (?) to this case, but did not see him again. Then there are other cases where the symptoms are not like the more ordinary ones attending fits, where sensation is more or less affected, but where there is simply loss of motor power. Of course, in a complete fit with loss of consciousness the patient falls, being totally paralysed, and loses all sensation.

The question arises, Can these occur in a partial way? My own opinion is that they can; and just as a blow on the head produces concussion accompanied by want of power of movement or of feeling of the whole body, so there might be a concussion of one-half producing a temporary paralysis of motion and sensation of one side, but without loss of consciousness; and in same way spontaneously portions of the brain or upper part of the cord might become affected, giving rise to those conditions

so often met with in epilepsy. A man, aged 50, said that for five years he had been subject to attacks of loss of feeling in his feet and legs; this sometimes proceeded to the arms. The attack came on without any warning.

Another patient, aged 50, came to me saying that two years before, whilst in his office and rising to meet a friend he fell down, but did not lose consciousness. He got up and walked to his chair. Soon afterwards, whilst shaving, the razor fell from his hand. Besides these attacks of momentary loss of power, he has whilst sitting a sensation like a galvanic current running up his back. In the night he has awoke and found one arm and leg quite numb. A clergyman came to me for falling of his jaw. It did not occur whilst talking, but whilst sitting quiet his jaw fell and sometimes quivered. Nothing local was discoverable as a cause. Another patient said that whilst walking, he was suddenly seized with complete loss of power of his legs; in-doors, sometimes he would feel as if all power were going out of him, and he was quite unable to speak. His jaw dropped, and his wife, if present, held up his jaw until power returned. He was connected with the engineering department of a colliery, and he said it appeared to him as if the machinery of his body was working quite regularly when suddenly there was a reversal of the engine.

A very remarkable case was that of a man, aged 30, who complained of a sudden loss of power of his limbs. He first noticed this whilst driving; his arms fell, and the reins dropped out of his hand. He almost immediately recovered the power. At another time his legs suddenly gave way beneath him. Sometimes whilst speaking his power of articulation would suddenly go, and at other times other muscles of the head would be affected; he could not swallow, spit or cough, and he saw double. When he came to me he was well, and appeared a healthy young man. I saw him some months afterwards with a friend, and he said he still had the attacks, and quite lately he was carrying rather a heavy weight, when his legs gave way under him and he fell down.

I mention these cases in connection with epilepsy seeing that

true epileptics have these strange attacks in their limbs. I would not, however, say that in all cases they were of the same nature, and had the same pathology as epilepsy, although they might be. As before said, when a person falls, his body paralysed, it is connected with loss of consciousness. It may occur in epilepsy, but the simplest case is that of syncope. Where in epilepsy one limb is especially affected, it is supposed to mark a local affection of the brain; and so I take it that as in syncope the function of the whole brain has become momentarily in abeyance, in these cases it is a partial cerebral syncope, or rather local. A local temporary paralysis may thus be compared with a local spasm, as when a person is suddenly seized with a lockjaw so that he cannot speak. I am fully aware that these temporary paralyses, having their origin both in the brain and cord, are met with in various organic diseases of these organs. I have seen them in general paralysis, and more than once in ataxia and other diseases of the spinal cord, called then reflex.

Having thus divided the epileptic attack into its several parts, and seen how each one may predominate, if not be the only symptom, I have now left for consideration the final one, which usually succeeds to the ordinary attack—the sleep, drowsiness, or coma. I now ask, May this be the only symptom of epilepsy? I have reason to think it may, and to this part of my subject I wish for the opinion of the society either for or against, as I think nothing much has been written upon it. There may be those present who would object to coma forming the essential or only part of epilepsy, seeing it would not accord with their definition or theory of the disease; but I am at present putting aside all considerations of this kind, making my paper purely clinical.

A young lady, aged 19, gradually became insensible, and fell into a deep sleep; when awoke went to sleep again. After an interval of some weeks she had another attack, when she fell into a state of almost complete insensibility, and slept for hours. She has had similar attacks since. Nothing was observed in the shape of convulsion or twitching of the muscles before the coma came on; but on closely questioning her as to her feelings before these attacks, she said she sometimes experienced a strange feeling in her right arm, leg and face.

A gentleman of middle age was under my care for symptoms of a syphilitic nature, having nodes on the head with much pain. He one day, whilst sitting at dinner with his niece, who took charge of him, complained of feeling unwell and sleepy, and said he should go to bed. He walked upstairs and was assisted into bed; he soon fell into a deep sleep from which he could not be roused, and a medical man was sent for. He was found to be in a profound coma, so that nothing could rouse him. I then saw him and we all thought he was dying, but after about ten hours he became wakeful and shortly came to. On the following day he was again downstairs as usual. It was clear that nothing of an apoplectic seizure could have occurred. About two or three weeks afterwards he was seized with a true epileptic fit, followed by profound coma, which lasted several hours, as in the previous attack. He again quite recovered, but subsequently had another. It occurred in the evening, when he began to feel heavy and went up to bed, and soon sank into a comatose state. He lay thus for several hours as before, and then recovered. His niece and his nurse, who were quite prepared for a fit, on the closest questioning, declared he had no warning or premonitory symptom of any kind before the coma came on. The niece was always watching him, and is sure that the slightest twitching of the face would have been noticed by her. It seemed to her, and also to me, that he would fall exactly into the same coma as he did when he had the regular fit.

Now, if coma be the only symptom of epilepsy, we may ask whether a partial insensibility may be of the same nature. I have already alluded to the mental aberrations of epileptics—how they will walk about in a dazed condition and be guilty of strange acts, and how such mental states may sometimes be the only indication of the paroxysm. Now, I ask, may such a condition occur and have epilepsy for its nature and pathology without any other symptoms ever having existed? For example, a boy of 14 was brought to me, who was said to be intelligent and had obtained prizes at his school. In two years he had had several attacks of the following nature: His mother would observe that when he came home he would seem very dull, sit in

a chair, and not speak except addressed. He would be led up to bed or led anywhere like an automaton or a person hypnotised. He had no fit and no loss of consciousness ; had several attacks of this kind. The last having continued three days, she brought him to me. He sat down in my study and said nothing, except in short words when addressed. He walked into other rooms when I told him, and then came back, doing anything he was bid. He had no other objective symptoms whatever. I saw him some months afterwards, and heard that the attacks were less frequent and shorter. He was a bright, intelligent boy, and presented a complete contrast to the patient I had before seen.

Sometimes an epileptic fit seems, as it were, drawn out ; then, of course, there is no sudden falling, as, for example, a young woman, aged 22, had curious attacks, which her medical man supposed were of an epileptic nature for the last six years. Whilst in the streets or elsewhere she would feel a numbness in the leg and arm on one side ; this continued for two or three hours, followed by headache. Sometimes the sight would fail on one side, but she never lost herself. If the attack came on in the day, she was unfit to go on with her work, for, as a rule, she wanted to sleep for hours afterwards. If one could imagine a fit which is usually all over in so many minutes protracted for several hours, one gets a notion of this case. Another case somewhat similar was that of a young man engaged as a clerk, and who for the last six years has had strange attacks. He feels a numbness creeping over his leg or arm of one side, and sometimes vision fails on one side. This feeling may last two or three hours, and is then followed by headache, which also lasts some time, and then sleep comes on. If these attacks occur during the day, he is obliged to desist from work, as he feels headachy, sleepy, and generally queer. He never loses his consciousness. What he described was an epileptic attack long drawn out, an attack in which all the symptoms were spread out over a length of time, the greater part of a day. If they had been compressed into a short period they would have constituted an ordinary epileptic fit. In his case there obviously could not have been any loss of consciousness.

Now, having mentioned a number of symptoms which may be of an epileptic nature, there remains another disorder which many authors think is closely allied, if not of the same nature as epilepsy. I mean migraine. For many years I have closely watched this subject, and I have no reason to support this view; in fact, my own experience is opposed to it. The main reason which authors have in associating the two is that the two complaints are both paroxysmal, and therefore they become placed together under the same heading in medical works. But periodic attacks of complaints in no way make them allied; and then in these two particular cases how different are the paroxysms. In one case the attack may come on suddenly, without any warning, so that the patient falls down in the streets, or into the fire; whilst in the other case the headache may be coming on for hours before it reaches its climax. This suddenness in epilepsy shows the attack is not anticipated, whereas an attack of migraine may be not only foretold, but produced at will. Many persons tell me that sitting in an atmosphere containing much carbonic acid will invariably produce an attack; others say a visit to a picture gallery will induce it; others the smell of flowers. I do not see myself the slightest resemblance between a symptom brought on at any time by an act of the will, and another which shows a periodic explosion of the brain occurring only at given intervals. This fact alone in my mind shows a complete separation of the two complaints. Then the symptoms have nothing in common; in the one there is the violent convulsion, dilated pupil, congestion, and often heat of body; in the other a cold skin, contracted pupil, sickness, etc. Then it is said that, although they thus differ in outward phenomena, they may own the same cause and replace one another. This is a question of observation and fact. For my part I have no experience of it. I know a large number of migrainous persons and migrainous families, but I do not see megrim and epilepsy replace one another. The epileptic does not suffer from headache. This fact I arrived at many years ago, after the discovery of syphilitic disease of the cranium, of the membranes or surface of the brain, producing fits. For in these cases a local pain is present, and therefore it constitutes a

diagnostic difference between these and simple epilepsy. It has therefore always been an inquiry on my part as to the existence of pain, and it may be stated as an absolute fact that the ordinary epileptic does not suffer from pain in his head. Then it is again said that if the two complaints do not occur together they may be seen in the same family, one member having the one complaint and another member the other. I have no knowledge of this, but, on the contrary, believe that the migrainous patient and the epileptic belong to a different class of persons. It is true that both affections are nervous, but the migraine occurs in persons of highly-strung nervous system—in the neurasthenic—whilst epilepsy occurs in persons who show no such tendency, but often in the dull and stupid. I have seen it somewhere written that migraine is a disease of the upper classes, and I think there must be some truth in this; for if I take men, I do not remember ever-prescribing for the complaint amongst our out-patients, whilst epilepsy is common enough; nor can I understand how it could occur amongst them; and what would happen if our soldiers, sailors, policemen, and engine-drivers had attacks of migraine which for some hours would quite incapacitate them from their duties; and yet I never heard a man being declared unfit for these duties from having headache. If I wished to find epileptics, I should go to lunatic asylums or idiot asylums amongst the low and undeveloped; and, on the other hand, seek amongst the bright and intellectual for migraine; and if, moreover, I wanted to gain any information about the complaint, I should read the *Philosophical Transactions*, where are recorded the histories of many distinguished men who suffered from it.

I have now cursorily alluded to various phenomena associated with the disease known as epilepsy. Many of these are well known, and need not be further commented upon. The part of my paper on which I should like the opinion of the meeting is that where coma is spoken of as the only symptom, and also on that in which I have suggested that a fit may be drawn out or protracted over several hours. I should also like to hear the views of the meeting on the question of the alliance of epilepsy and migraine. I have stated my opinion as opposed to it; but

since many distinguished authors have of late been in the habit of placing them together, I am quite open to any further observation or facts which may tend to strengthen the position they have taken.—(*British Medical Journal*, Jan. 2, 1892.)

Action of Yeast on Typhoid Bacilli.—

Recently Dr. Springthorpe, at a meeting of the Victoria Branch of the British Medical Association, communicated a description of M. de Bavay's results of a series of observations and experiments on the saccharomyces and their relation to typhoid bacilli. These saccharomyces were obtained from chyle which had escaped from the thoracic duct through an ulceration, and which appeared to possess very strong antiseptic and deodorising properties. After determining that the typhoid bacillus grew best in broth, and that milk was not a specially good medium unless it could be previously peptonised by other materials, M. de Bavay carried on a series of experiments to prove that yeast had the power of interfering with the growth of the typhoid bacillus when the two were cultivated *in vitro*. He found that the typhoid bacillus growing in an alkaline medium was much more virulent than that organism growing in an acid medium. He explains this on the assumption that the poison secreted by the organism is immediately precipitated in the alkaline medium, leaving the bacillus free to act, whilst in the case of the acid medium the poison is not precipitated, and eventually accumulates to such a degree that the organism which secretes it is itself poisoned. He found also that if he retained the sediment from an alkaline solution on a filter, and then dissolved it in a weak acid, he obtained an exceedingly toxic substance. From this he argues that as yeast is able to pass through the intestine comparatively unchanged, and as it develops a considerable quantity of acid in its growth, it should, if introduced into the intestinal canal, maintain a certain acidity in the contents, and so prevent the precipitation and storing up of the typhoid poison—a storing up which takes place when the secretion is allowed to remain alkaline. He also holds that if the food taken by the patient be saturated with yeast—which is a harmless organism—

the typhoid bacillus can no longer develop in it, and is therefore very soon starved out, and he maintains that in consequence of this slow absorption of the acid into the system a kind of self-protective inoculation takes place; in fact, after injecting a mixture of yeast and typhoid bacilli, guinea-pigs which had shown slight signs of intoxication but had recovered were proof against large toxic doses of the poison. He describes an organism found in certain cases resembling typhoid which secretes a far more poisonous compound than does the typhoid bacillus itself, which, however, it resembles in many respects, although it develops rapidly on potato, forming an abundant wax-like covering. The colonies on gelatine are exceedingly minute; the bacilli are like those of typhoid but a little stouter; they are arranged in chains of two, three and four, and have a serpentine motion across the field of the microscope; they stain readily, and are then very similar to the bacilli of septicæmia. Here, however, the poison appeared to belong to the class of albumoses, whilst the typhoid poison he considers to be a ptomaine. His conclusions are (1) that the action of yeast in the treatment of typhoid fever is principally due to the power which it has of secreting an acid, and of doing this over and over again, by which means it is able to render acid the contents of the intestines; (2) that when such an acid reaction exists, the poison secreted by the germ reacts upon the germs themselves and stops their growth; (3) that the action of yeast on the poison of typhoid differs according to whether it is pure or contaminated by bacteria; (4) that liquids impregnated with yeast are in a great measure protected against the depredations of typhoid bacilli, especially if such a liquid contains a fermentable sugar; (5) that these properties of yeast are not confined to one variety, but that they increase or diminish according to the power of assimilation and acid secretions of different varieties. Further, he has found that the typhoid bacilli, after repeated growth in peptonised broth, produce less poison, as it is necessary to use larger doses to produce the same effect.—*Supplement to British Medical Journal.*

Vagabondage.—Certainly no humane and enlightened person wishes for a return of the days when witches were burned, the insane were whipped, and neurotics were consigned to the penitentiary. Many human failings, which in the night of the Middle Ages, or even within the memory of men still living, were regarded and punished as sins, vices or crimes, are at present held to be diseases, or, at most, morbid immoral tendencies, and their victims are now received into hospitals or asylums where physicians preside. This reformation has been aptly termed the war of conquest, which the medical fraternity has successfully waged against the magistracy.

A recent lecture, in which a foremost worker in this field of reform, Prof. Benedikt of Vienna, had the insight and courage to defend the so-called "tramps" from the severity of the existing laws directed against them, deserves notice in our pages. We cull from the report of a late Berlin journal, *Der Zeitgeist*. Dr. Benedikt, in this lecture, defines vagabondage to be either acquired or natural. In the acquired form, two groups of vagabonds are distinguishable. In the first group belong convalescents prematurely discharged from hospitals, who are temporarily incapable of work. This group is further composed of chronic valetudinarians, of sufferers from senile debility, and of individuals intellectually or morally weak. The second group consists of persons that have been plunged into misery by pecuniary reverses of fortune and the like. None of these accidental vagabonds should, according to Dr. Benedikt, be subjected, as now happens, to the penal laws. They have a claim upon society for charitable support, either in convalescent hospitals and asylums or by the provision of wages commensurate with their earning capacity, or by outright pecuniary aid.

Among the individuals who have acquired vagabondage, Dr. Benedikt further classes such adults and children as at birth were free from all psychological tendency to this state, but who, through neglected education, enticement from the path of duty, intolerable environments and the like, have been transformed into vagabonds, and have also, perhaps, won still worse defects of character therewith, such as drunkenness.

In his category of natural vagabonds, the Professor cites young children that appear to have been innately designated for a vagrant's existence, and who already gave, during the innocence of infancy, psychological tokens of the vagabondage to which they were predestined.

In the task of redeeming adult vagabonds much success has attended their judicious constraint to work, but with young subjects a less happy outcome of attempts in the same line has been observed, probably because the latter are mostly recruited from children who have suffered from great moral neglect. For the protection of society against incorrigible and hopeless vagabonds Prof. Benedikt would have all those that are found, on judicial inquiry, to be permanently or by relapse wedded to their habits, consigned by decree of court to appropriate institutions for their detention and treatment.

According to the view taken by the lecturer, the psychological ingredient most essential to vagabondage is a natural or acquired aversion to labour, which itself depends upon asthenia of the will. Whence it comes that persons who, through sheer irresolution, are incapable of labour, become fitted for effective work when under adequate supervision they are constrained thereto. A second important element is the shallowness and fickleness of the subject's character, and this is the soil which is most prolific of the professional vagabond or tramp. A third elementary cause of vagabondage is designated by Dr. Benedikt as claustrophobia, under the operation of which, individuals, as has happened to entire tribes of men, become powerless to abide in confined and unchanged localities. Another noteworthy factor he finds in a certain psychical state of unrest which prevents the afflicted possessor from persevering in any one continuous and coherent line of effort, but he veers to every shifting suggestion or impulse.

While discussing the relation of vagabondage to crime, Dr. Benedikt instances the remarkable phenomenon that vagabonds may prove themselves to be the veriest knights of honesty and virtue, and may suffer privation, misery and despair without once giving way to a criminal act. On the other hand, remarks the lecturer, vagabonds frequently commit crimes for the sole

purpose of being committed to prison. It is characteristic of this description of offences that they are usually perpetrated in the presence of the public or of the police authorities. In a paroxysm of extreme exasperation and despair, the tramp sometimes commits an atrocious crime—his alleged grounds therefor being that he courted extreme punishment and even death.

In conclusion, Dr. Benedikt vividly describes and emphasizes the impression made on him by a visit to Merksplatz, where four thousand Belgian vagabonds were colonized. The Belgian Minister of the Interior gave the prestige of his authority on the occasion by patiently accompanying the Professor throughout his visit, and the latter succeeded in classifying that whole vagabond community into scientific groups. The actually insane did not fill an insignificant category. Prof. Benedikt adds: "How magically such a demonstration *ad oculos* succeeds in clearing up a great social problem, with which the psychologist only is competent effectually to deal."—*W. W., in Alienist and Neurologist*, January, 1892.

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**THE NATURE AND TREATMENT OF INFLUENZAL
PNEUMONIA.**

The treatment of pneumonia is a subject that is constantly being forced on the attention of the practitioner. Of late, the number and severity of cases of this disease have been increased. This is chiefly due to the epidemic of influenza which has been so universal. In old people especially, pneumonia is not an infrequent manifestation of the influenza poison. In the great majority of these cases it is a broncho-pneumonia that we have to deal with, croupal pneumonia being rather an uncommon manifestation or complication of the disease. The broncho-pneumonia of influenza clinically differs somewhat from the same disease coming after measles or whooping-cough, and also from the broncho-pneumonia which is met as the result of a chronic bronchitis in old people.

Influenzal broncho-pneumonia is characterized by being more extensive—by being more prone to affect in rapid succession different areas of the lung texture. Another feature is that the respiratory distress is often out of proportion to the extent of the pulmonary exudation. This points to the involvement of the bulbar centres. These may be excited or depressed. Sometimes the respiratory centre is alone involved, and sometimes the cardiac alone: often both together. One may be irritated while the other is depressed. It follows, therefore, that the cardiac and respiratory symptoms may be very various.

As to the treatment of influenza pneumonia, every cautious physician must be particularly struck with the two-edged tools

that are so carelessly employed. In a recent journal we have a prominent physician giving us the advice that *veratrum viride* is good in influenzal pneumonia. We have no hesitation in characterizing such treatment as bad—utterly bad. If there is one thing surely established, it is that cardiac depressants are bad in all secondary pneumonias. We think that this is true not only of secondary, but also of primary pneumonias,—in fact of all pneumonias. Whatever is done in influenzal pneumonia, it should be such as has a stimulating influence. The tendency to death is through cardiac and respiratory failure. To prevent this, the most important means that we have are the use (1) of alcoholic stimulants, (2) digitalis and strychnine, and (3) oxygen inhalation. By the judicious employment of such agents, with strict attention to general hygienic and dietetic measures, we fully believe that we are adopting those measures which the science of the present teaches us as being the most useful in the conditions named.

ETHICS OF MEDICAL JOURNALISM.

The editor of a medical journal should, one would naturally think, be the last man in his profession to make use of any means not strictly honourable to further his aims. One would expect, to say the least, that such a responsible position would be filled by a man who not only respected the letter but also the *spirit* of the law.

In looking over our exchanges, we are frequently reminded of the great lack in true professional ethics displayed by many of them. In one column may be found just condemnation of mountebankism in one of its many forms, while in another the same *we* is "telling his readers why his journal is the best that can be purchased for the money. It is the journal, above all others, which deals with the practical aspect of medicine. Some journals give as many as a dozen reasons which in their opinion entitle it to be considered before all others. Such assertions may be true, or they may not. Generally speaking they are not. Whether true or false, no editor should condescend to

resort to such means of making money. Why a reputable practitioner should use such means of gaining a little kudos as medical editor and scorn to make use of them in his medical practice proper is difficult to understand? The same ethics that is proper for the practitioner should also be adopted by the medical editor. Self-laudation is not confined to any particular class of medical journals. It is to be found in monthlies, bi-weeklies and weeklies. Probably the great English and American weeklies are more prone to this self-praise than any others. There are a few noticeable exceptions. The French and German medical journals of all classes are almost entirely free from any such puffing. The Anglo-Saxon editor finds no doubt that it pays to resort to such means. Charlatans make use of similar means for similar reasons.

After all, no one particular medical journal is so valuable or so important that its non-appearance would be felt as a great loss by the profession.

Obituary.

JAMES BOWIE, M.D.

It is with great regret that we record the death of Dr. James Bowie, late of Mitchell, Ont. Dr. Bowie reached the great age of 90 years, and for upwards of sixty years practised his profession. He graduated in medicine in the University of Glasgow in the year 1825; shortly afterwards he began the practice of his profession in St. Johns, Que., but after a short stay he removed to St. Eustache, where he remained for many years. During the "unpleasantness" in 1837, Dr. Bowie was attached as surgeon to the Royal troops, and in that capacity he was present at the battle of St. Eustache. During the fearful epidemic of typhus fever in this city in 1847 Dr. Bowie was acting medical attendant to the hospitals situated at Point St. Charles, and during this trying period he contracted the disease. He, however, quickly recovered and continued his work, which to him was a labour of love. After the subsidence of the epidemic he removed to Mitchell, and in that town he passed the remainder of his professional life.

After retiring from practice in 1883 he has resided with different members of his family in Montreal, Chicago, Seaforth and Brockville. It was while visiting his son, Mr. D. E. Bowie, barrister, of this city, that he contracted influenza. This was followed by a catarrhal pneumonia, which rapidly proved fatal.

As a practitioner in Mitchell, Dr. Bowie was highly respected and sought after. For many years he was the leading practitioner in that district of country. He has passed away, full of years, respected and beloved for his many sterling qualities.

D. J. M. HAGARTY, M.D.

After a prolonged illness, D. M. J. Hagarty, M.D., of Portage la Prairie, Manitoba, passed away in California where he had gone with the hope of prolonging his life. Dr. Hagarty graduated in McGill University in 1866, and after practising some years in London, Ont., he removed to the North-West, and early succeeded in establishing a large and lucrative practice in Portage la Prairie. He was an able practitioner, and his loss will be felt keenly by his many friends and patients.

FINDLAY McEWEN, M.D.

It is with sincere regret that we record the death of Findlay McEwen, M.D., of Carleton Place. He graduated in medicine in McGill University in 1870, and has ever since resided and practised in Carleton Place. As a practitioner and citizen he was highly esteemed.

Medical Items.

—Prof. Kast of Hamburg succeeds Prof. Biermer as Director of the Medical Clinic in the University of Breslau.

—W. B. Saunders, publisher, of Philadelphia, announces the two following important works as being in the press :—

“An American Text-book of Surgery,” by Professors Keen, White, Burnett, Conner, Dennis, Park, Nancrede, Pilcher, Senn, Shepherd, Stimson, Thomson and Warren. Forming one handsome royal octavo volume of about 1200 pages (10×7 inches), profusely illustrated with woodcuts in text, and chromo-lithographic plates : many of them engraved from original photographs and drawings, furnished by the authors. Price, cloth, \$7.00 ; sheep, \$8.00.

“An American Text-book of the Theory and Practice of Medicine, according to American Teachers,” edited by Wm. Pepper, M.D., LL.D., Provost of the University of Pennsylvania. To be completed in two handsome royal octavo volumes of about 1000 pages each, with illustrations to elucidate the text wherever necessary. Price, per volume, cloth, \$5.00 ; sheep, \$6.00 ; half Russia, \$7.00. For sale by subscription only.

—E. B. Treat, publisher, New York, has in press for early publication, the 1892 “International Medical Annual,” being the tenth yearly issue of this deservedly popular work. Its corps of thirty-five editors are specialists in their respective departments, and have been carefully selected from the brightest and best American, English and French authors. It is the embodiment of what is worth preserving of the current medical journals of the world for the year, and will contain over 6000 references to diseases and their remedies. The service rendered the profession by this Annual cannot be over-estimated, and it is an absolute necessity to every physician who would keep abreast with the continuous progress of practical medical knowledge. This Index of New Remedies and Dictionary of New Treatment, epitomized in one ready-reference volume at the low price of \$2.75, makes it a desirable investment for the busy practitioner, student and chemist.