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THE
MEDICAL CHRONICLE.

VOL. VI.]

APRIL, 1859.

[No. 11.

ORIGINAL COMMUNICATIONS.

ARTICLE XXVII.—*Excision of the Shoulder Joint.* By ROBERT L. MACDONNELL, M.D., Surgeon to St. Patrick's Hospital, Montreal.

Ambrose C., a delicate, scrofulous lad was admitted under my care, into St. Patrick's Hospital, April, 1858, labouring under a chronic disease of the right shoulder joint.

He stated that he had received several severe injuries on that shoulder two years before, from having been thrown on the ice frequently whilst playing with other lads, in the amusement of *sleighing*. The next day he experienced severe pain in the joint, which soon became swollen, and eventually, abscesses formed, and burst externally, and matter continued to flow freely for several months from twelve sinuses, which on being examined, were found to lead down to diseased bone. Some of the sinuses were connected with the anatomical, some with the surgical, head of the humerus, whilst others ran towards the coracoid and acromion processes. None of them took a direction towards the ribs.

The shoulder was much swollen, of a deep red hue, and of semi-cartilaginous consistence. The redness and alteration of structure extended to the insertion of the deltoid, and the axilla was filled up with a similar hard and resisting substance. The motions of the joint were lost. When an attempt was made to move the arm, the scapula moved with it, and the arm could not be moved from the side, to which it appeared firmly attached by the condensed structure occupying the axilla.

When he made an attempt to raise the arm, it was easily perceived that motion was confined to the scapula alone, and that the humerus did not participate in it. The elbow joint was free from disease, and the forearm and hand were strong and their muscles well developed.

As this condition of the parts did not improve, and as the patient's health was rapidly declining, owing to frequent attacks of diarrhœa, vomiting, and constant pain, I proposed to him, to have an operation performed, by which the head of the humerus and any diseased bone in the vicinity of the joint should be removed, to which he gladly consented, being most anxious to obtain relief, at all hazards.

Assisted by my colleague Dr. David, I performed the following operation:—A semi-lunar incision was commenced at the point of the coracoid process and carried downwards and outwards towards the root of the acromion, extending downwards to near the insertion of the deltoid, and so directed, as to take the flap more from the back part of the joint than the front.

The knife cut through a hard brawny substance, of a whitish color, and scarcely vascular, and as soon as the incision was made, the flap retracted, as if it were composed of india rubber tightly stretched over the joint, and a deep narrow cavity was exposed, the walls of which were composed of eroded bone. There was no trace of the capsular ligament, nor of the tendons of the scapular muscles, nor of the long or short head of the biceps. It was soon ascertained that the boundaries of this bony chasm were formed by the end of the shaft of the humerus (for no portion of its anatomical neck remained) and by the neck of the scapula, the under surface of the acromion and coracoid processes. The surfaces of these bones were covered with sharp and hard spiculæ and processes which were interlocked with one another, so as to make it impossible to move the humerus without moving the scapula also. The space between the humerus and the remains of the glenoid cavity barely admitted the introduction of the index finger. All efforts to "turn out" the end of the humerus proved ineffectual; its surgical neck seemed bound by the condensed structure of the axilla to the thorax, and could not be separated from it, and no space could be procured, wherein to work the smallest saw. Under these circumstances the plan of operation was at once changed. An incision was carried from the one already made downwards, on the external surface of the humerus for the distance of three inches, and the soft parts being carefully dissected from the bone, I was able to remove, by means of a cutting forceps about two inches and a half of the diseased extremity of the bone, together with the neck of the

scapula, and the extremities of the acromion and coracoid processes. As the forceps did not answer for all parts of the operation, the gouge was freely applied until a healthy bony surface was exposed throughout. During the operation, which was necessarily more protracted than was anticipated, he lost a good deal of venous blood, and the proceedings had to be stopped three or four times until he regained sufficient strength to enable me to continue. The greatest care was also bestowed upon the administration of the chloroform. Notwithstanding the size of the wound, and the vascularity of the integuments, there was only one small artery cut (the anterior circumflex), and this did not require a ligature. The edges of the wound were brought together with difficulty, for in order to keep down the upper flap, I was obliged to use hare-lip pins, so great a tendency did it exhibit to retract upward over the point of the shoulder.

Water dressing was applied to the wound, an anodyne administered, and nutritious diet prescribed.

The following morning he was in good spirits, and stated that he had passed a quieter night than he had done for several months past. He suffered no pain in the shoulder, and was quite free from fever.

It is unnecessary to detail the daily changes that took place in the wound. I may mention that I took no precaution about keeping the limb raised, or in a fixed position; in fact, I neglected much of the advice given on this point in surgical books, as I believe a good deal of it is suggested by theory, and not by practice. I allowed the patient to please himself on this point; and I had no reason to regret leaving him to manage matters for himself, for, on the sixth day after the operation, he was walking about the ward, and could move the elbow from the side to a distance of about eight inches, and the scapula could be elevated, carrying with it the arm, without any increase of pain; and, at the termination of the fourth week, he was able to hold a vessel in the hand of the affected limb, to receive the fluid of an abdominal dropsy I had tapped, and steadily continued at this task until the last drops of the fluid were drawn off. I mention this circumstance, as showing what power the limb had acquired, for the test is one, which even a strong person, with perfect use of the arm and shoulder, would feel tiresome, and difficult to sustain.

He remained in the hospital for some weeks longer, during which period all the sinuses closed but one. His health became much improved, and he left with the intention of earning his livelihood as a pedler. He frequently called at my house during the autumn, and, on each occasion, an increase of power of the limb was remarked.

Within the last few weeks, I have heard from his sister that he was attacked during the winter with inflammation in the bowels, and died after a short illness.

I am sorry that I had not an opportunity of examining the shoulder. It would have been interesting to ascertain the exact condition of the tendons of the scapular muscles, and those of the biceps, triceps, coracobrachialis, pectoralis minor, pectoralis major, and latissimus dorsi.

In the method of operating, I proposed following the plan of Malgaigne, who makes a flap of the deltoid, including the capsular ligament, in the same sweep of the knife; and I also intended to follow the precept of O'Bierne—to get into the cavity of the joint, by running the scalpel up the bicipital groove, taking the long head of the biceps as a guide. I do not know if I am correct in assigning this suggestion to O'Bierne, but it was from him I learned it, and I have found it an easy, expeditious and quick method of getting into the joint, and it does not involve the division of the tendon of the biceps, until necessity demands the performance of this step of the operation.

I had, at the same time, two other cases of disease of the shoulder joint in the hospital. One of them afforded a strong contrast to that just detailed. The patient was a delicate scrofulous young man. In him, the disease had been of several years standing, and instead of an increase in size, the prominence of the shoulder was gone, and the outline of the humerus and the acromion and coracoid processes could be plainly seen and easily felt; and the arm and forearm were much atrophied. Two sinuses in the front of the joint led down to bare bone in the vicinity of the surgical neck of the humerus, but as he suffered very little, and had regained considerable use of the limb, and as his general health was daily improving, I looked upon the case as one in which nature was making an attempt to produce ankylosis, and consequently did not consider myself justified in interrupting that process by surgical interference. The other case was that of a stout, middle-aged woman, who had received a severe injury of the left shoulder six months before, which had been followed by acute inflammation, ending in false ankylosis. The arm was fixed to the side, and she could not make any attempt to separate the elbow from the side, or to raise the hand to the head. It was my intention to have administered chloroform and to have broken up the adhesions; but whilst examining the joint, she accidentally slipped off the chair upon which she was sitting, and, in my efforts to keep her from falling, I jerked the arm up, whilst her great weight carried the body and scapula downwards; a loud crackling noise was heard, and the motions that I had intended communicating to

the arm, were thus rudely and unintentionally given to L. Notwithstanding, she made an excellent recovery, perhaps a better one than if she had been more scientifically treated.

ARTICLE XXVIII.—*Two examples of Myeloid Tumor; with general observations upon that form of growth.* By R. P. HOWARD, M.D., &c., Prof. Clinical Medicine, McGill College, etc.

(Continued.)

Gentlemen,—The term myeloid was proposed by Mr. Paget,* for a class of tumors first described by Mr. Lebert in 1845, under the title "*Tumeurs fibro-plastiques ou sarcomateuses.*"† The latter pathologist included under this head growths whose histological structure consisted chiefly of elongated fibre-cells, like those found in granulations, or contained in addition, "mother cells," i. e. cells containing several distinct nuclei, identical in character with those of the diploe and marrow of fœtal bones. The former pathologist regards growths composed chiefly of the many-nucleated cells as quite distinct in nature from those made up of elongated fibre-cells, although, he admits that both these structures usually co-exist in the myeloid growth; and to obviate objections, I have not, except in one instance, tabulated any tumor which did not contain the poly-nucleated cells in sufficient abundance to justify the application of myeloid: the exceptional case however, in its clinical history and anatomical naked-eye characters admits of no other allocation.

It is not my intention to furnish you with an account in detail of the history,—clinical, pathological and histological, of myeloid tumors—this you will find in the works of the authors above mentioned, and in two excellent papers, in the *Medico-Chirurgical Transactions* for 1856, and *Guy's Hospital Reports* for 1857; the former by Mr. Henry Gray; the latter by Dr. Wilks.

I purpose merely giving the results of my examination of some of the features presented by 38 specimens of the disease recorded by competent authorities. The table appended to this paper supplies the materials employed, and the sources whence they were derived. There are four additional cases tabulated separately, as some doubt exists as to whether they were purely myeloid growths or not.

1. Myeloid tumors appear to occur with about equal frequency in both sexes; thus, of the 38 cases, 15 were males, 18 females, and in five the sex is not stated.

* Lectures on Surgical Pathology, American edition, p. 445.

† *Physiologie Pathologique*, tome 2, p. 120.

2. An apparent exciting cause is mentioned in 10 instances ; it is not alluded to in 15, and is said to be absent in 13. In the 10, an injury of the part is the cause assigned, which is about $\frac{1}{4}$ th of the whole number, a larger proportion than is assigned to injuries ($\frac{1}{4}$ th) by Mr. Paget in the causation of cancer. The nature of the injury was, in 7 either a blow or fall, or succession of blows, and in the other 3, respectively, a sprain, a strain, and a slight injury while swinging.

3. The frequency of myeloid disease at various epochs of life was as follows :

YEARS.	
From 12 to 20—	9 cases.
20 to 30—	14 “
30 to 40—	4 “
40 to 50—	2 “
50 to 60—	0 “
60 to 70—	0 “
70 to 74—	1 “
—	—
	30

4. It is an interesting feature in the history of myeloid tumors of bone as compared with cancerous, that the former occur chiefly before 40, while the latter are almost as frequent after 40 ; thus, of the 30 cases of myeloid tumor in which the ages are shewn, 27, *i. e.* 90 per cent were under 40 ; 3, *i. e.* 10 per cent were over 40. Of 54 cases of cancer of bone (*) 33, *i. e.* 61 per cent were under 40 ; 21, *i. e.* 40 per cent were over 40. On the other hand, it is not a little singular that cancer is of equal frequency with myeloid in early youth, say under 20 : thus, of 54 cases of cancer, 21, *i. e.* 39 per cent were under 20 ; of 30 cases of myeloid, 9 *i. e.* 30 per cent were under 20. If the comparison be extended to the decade between 20 and 30, it will be found that myeloid disease of bone becomes much more frequent at that period of life than cancerous. Thus, of 30 cases of myeloid, 14, *i. e.* 47 per cent occurred between 20 and 30, while of 54 cases of cancer, only 11, *i. e.* 20 per cent occurred between 20 and 30. Hence, if such limited numbers may be relied on, it follows, that if the patient be over 40, the chances that a tumor of a bone is cancer rather than myeloid are as 40 to 10 ; if between 20 and 30, the chances are in favor of myeloid, as 47 to 20 ; but if under 20, they are about equal.

5. The proclivity of the bones, especially of the long bones, and of these, their articular extremities, to myeloid tumors is shown by the table ; thus, in 34 of the 38 cases, the bones were the parts affected ; of

(*) Paget's Surg. Pathology, p. 55.

these, 25 were long bones, or 73 per cent; and of the whole 25 the disease occupied the articular ends.

Even in the 4 cases in which osseous tissue was not involved, the growth was attached to the periosteum 3 times, and the dura-mater (analogous to periosteum) once.

The special sites of the tumors were as follows:—

Condyles of femur.....	in 12
Head of tibia.....	in 7
Upper extremity of fibula.....	in 2
Lower extremity of fibula.....	in 1
Head of humerus.....	in 2
Lower end of radius.....	in 1
Superior maxilla.....	in 4
Inferior maxilla.....	in 2
Scapula.....	in 1
Patella.....	in 1
Vault skull.....	in 1
Dura Mater.....	in 1
About great toe.....	in 1
Outside radius at wrist.....	in 1
Periosteum of tibia near ankle.....	in 1

—
38

In one instance, (c 28) the growth had extended from the femur into the articulation and involved the patella and tibia; and in another, (c 38), the synovial cavity and space between the articular surfaces of the femur and tibia was occupied by the growth, and yet the cartilage covering those surfaces was intact. Myeloid disease, like carcinomatous, is extremely little prone to implicate cartilage.

6. The irritation excited by the growth in the head of the bone may, and frequently does excite inflammation in the contiguous articulation, but this is of an adhesive, rather than of a suppurative and destructive character. In the specimen now on the table, the cavity of the joint was obliterated by tolerably firm adhesions. In one of Sir. B. Brodie's cases, (c 7), old adhesions were found between the articular surfaces. The circumstance that the inflammation of the joint which supervenes upon myeloid disease of the articular extremity of a bone, is adhesive rather than suppurative, is not peculiar to that growth, for it has been observed to obtain in cancer invading the same locality, and is no doubt also the rule in cartilaginous tumors.

7. The cases collected furnish no positive information as to the duration of life when myeloid disease is permitted to pursue its course without surgical interference. Case 34, in which the growth engaged the dura-

mater, terminated fatally two months after the first manifestation of the head symptoms; case 24, in which the cranial vault was the site of the growth, closed with head symptoms three years after the first indications of the disease; how long these patients might have lived, had not the growths interfered with the functions of an organ essential to life, it is impossible to say; case 39, besides being of a doubtful nature, had its natural course modified, probably much accelerated by 35 tappings, 6 injections with iodine, and 2 setons.

8. An examination of these cases however, proves that the average duration of life after removal of myeloid tumors far exceeds its average duration after removal of cancer. Mr. Paget assigns as the average duration of life under these circumstances, 28 months for medullary and 49 months for scirrhus cancer. But of 24 persons who survived the removal of myeloid tumors, and the duration of whose disease is stated, I find that the whole number but two, were alive when the cases were published, and had then individually attained an average of rather more than 5½ years from the first indications of the disease. If the two deaths be omitted in the calculation, then the 22 individuals were all five years and eight months, on the average, after the disease had manifested itself by symptoms. How much longer they may have continued to live, is a problem for future solution.

9. It is significant moreover to observe, that the cause of death in one at least of the two deficient persons, was of an accidental nature; he succumbed to phthisis five years after the removal of the disease, and 5½ years after its first discovery (c 1). Acute pleurisy, which succeeded an operation performed "a few days" previously, induced the fatal termination in the other case, but myeloid tumors were also found in the lungs (37).

10. So far as we yet know, myeloid resemble innocent tumors in their little proneness to recur after removal. The first recorded instance of the re-appearance of pure myeloid tumor as myeloid, was published in the Medical Times and Gazette last January (c 37). About two years after the amputation of the patient's leg for myeloid disease of the head of the fibula, he discovered three tumors on the stump, which on excision proved to be myeloid; and at his death, which followed the removal of the tumors in a few days, the lungs were each found occupied by three or four myeloid tumors, the largest the size of the heart.

It is true, that it is only in 19 of the whole 38 cases of myeloid that it is stated whether the disease recurred or not, and in some of these, the period that had elapsed between the removal of the growth and the report of the case, appears rather short to have afforded the opportunity

for recurrence of the disease; however, two-thirds of the nineteen patients survived an average period of three years and five months without any return of the disease. The following table shows the interval which elapsed without recurrence between the removal and the date of publication of each case :

No. of cases.	Interval.
6 { 2	..... 1 month
{ 3	..... 2 "
{ 1	..... 6 "
12 { 1	..... 14 years
{ 2	..... 2 "
{ 1	..... 2½ "
{ 1	..... 3 "
{ 1	..... 4 "
{ 2	..... 5 "
{ 1	..... 6 "
{ 1	..... 7 "
{ 2	..... 10 "
—	
18	

Comparing pure myeloid with cancerous tumors, it may be said, that whereas recurrence is the almost invariable rule in the latter, it is the rare exception in the former; and while the great malignancy of cancer is shown in the rapidity of its recurrence after the removal, the interval being 7 months in medullary cancer and 14 months (*) for scirrhus, the comparative innocence of myeloid is proved by its non-recurrence after an average interval of 26 months.

11. That malignancy is but a comparative term, as remarked at the commencement of this paper, is shewn by the disease now under consideration. In one instance, related by a competent observer, Dr. Wilks of Guy's Hospital, a pure myeloid tumor recurred in the stump two years after the ablation of the original disease, and similar pathological structures were found in the lungs; the disease in fact, re-appeared both locally and remotely. The lymphatics were, however, not affected, the patient exhibited no signs of cachexia, and his death was due to acute pleurisy. (c 37).

Mr. Paget also, relates a case in which, while the microscopic and naked-eye characters of the tumor were those of myeloid, it exhibited some features of malignancy, for besides the presence of "four small masses of similar substance in the lungs," a "similar material was diffused in one of the cervical glands" (c 39). In this instance then, one lymphatic gland was contaminated, as well as the lungs; still, the patient exhibited no cachexia, but was of "healthy appearance."

(*) This rate is obtained by calculation made from Mr. Pagets' table at p. 525 of his work, American edition.

12. Our present knowledge of myeloid tumors not only proves that malignancy is not peculiar to cancer, although both terms are generally regarded as equivalents in pathological meaning, but tends to show further, (A) that the same growth may contain the comparatively innocent myeloid cells and the so-called specific cancer cells, and, (B) that a tumor apparently myeloid in structure, or, (C) mixed myeloid and fibro-plastic, may after removal be succeeded by genuine cancer both at the original site and in the internal vicera.

(A) The same growth may contain "myeloid" and "cancer-cells." A lad, ætat 18, had his leg amputated for a growth from the head of the fibula, which, in its general appearance, resembled other myeloid tumors"; but "it contained a large amount of bone mixed with the soft material." "Much of the myeloid matter was of a milky white colour, and to the naked eye resembled cancer. The microscope, however, showed true myeloid cells, but at the same time some very large single nucleated cells, elsewhere called "cancer cells" by the reporter. A few months after, the boy became paralysed, and growths, also containing *myeloid* and *cancer* cells, were found in the spine and in the lungs. This patient was markedly cachectic (c 42).

(B.) I have said a tumor apparently myeloid may be followed after removal by genuine cancer, both locally and remotely.

Mr. Paget records the history of a tumor of the mamma, which he concluded after careful examination to be "a myeloid tumor, suppurated or possibly mingled with cancer." Six months after its removal a tumor re-appeared in the axilla, grew large, ulcerated, bled freely, and was really open cancer (c 41).

(C.) A mixed fibro-plastic and myeloid tumor may likewise be followed by cancer. A remarkable case is related by Mr. Hutchinson of a tumor consisting of fibro-plastic and myeloid structures, the former largely predominating however, and involving the head of the humerus, the removal of which was succeeded in 10 weeks by genuine medullary cancer, both at the site of the previous operation and in the lungs. The lymphatic glands, although enlarged, contained no cells resembling cancer cells (c 40.) This last example is a further illustration of the difficulty of a rigidly accurate classification, for in the original tumor, two histological elements, now considered quite distinct and different, the fibro-plastic and the myeloid co-existed; teaching us in fact, that tumors in their structure are often compound, and are competent therefore to the occupancy of one, two, or three locations in the scale of classification, according as one or other of their histological elements is regarded as their essential characteristic.

12. If case 39, about whose real nature Mr. Paget expresses some doubt, (not that it wanted the naked eye and microscopic characters of myeloid, but that it differed from all that was then known of that form of tumor), be regarded as genuine myeloid, then there are two instances on record in which that growth implicated the internal organs as well as the external, and one in which a lymphatic gland in addition was involved, *i. e.* two out of 39 cases.

RECAPITULATION OF CONCLUSIONS RESPECTING MYELOID TUMORS.

1. They occur with about equal frequency in both sexes.
2. Local injury was the apparent exciting cause of the growths in about one-fourth the entire number, and in 13 of the 39 cases no cause could be assigned.
3. Myeloid tumors occur chiefly before 30 years of age, for 76 per cent of the cases were under that age, and 90 per cent were under 40; they may occur at as advanced an age as 74.
3. While myeloid and cancerous tumors are of about equal frequency under 20, myeloid are more frequent than cancerous in the ratio of 47 to 20 at the decade between 20 and 30.
5. The bones are of all parts of the body most prone to myeloid growths; in about $\frac{2}{3}$ ths of the cases it is the long bones which are implicated; and in perhaps all cases, the disease begins in and is confined to the articular extremities of such bones.
6. The condyles of the femur is the part of the body most obnoxious to these tumors, probably the head of the tibia next, and the superior maxilla next. Several other localities exhibit about equal susceptibility, *viz*: the head of the humerus, the head of the fibula and the inferior maxilla.
7. No bone is probably exempt.
8. Of the soft parts, it is chiefly the fibrous tissues, and especially those in proximity to bones and articulations, that are most liable to myeloid growths; but they have been rarely seen in the lungs, in the neck, in a lymphatic gland, and in the mamma; in the last site, it was probably associated with cancer.
9. These growths very seldom extend into an articulation; this event having been noticed only twice in 25 cases, in which the disease occupied the articular extremity of long bones: even should the articulation be entered by the growth, the cartilages are not usually implicated.
10. Secondary inflammation occasionally is excited in the contiguous articulation, but it is of an adhesive, rather than a suppurative character.
11. Data are wanting to determine the average duration of life when myeloid tumors are not interfered with.

12. The average duration of life after removal of myeloid tumors *far exceeds* its average duration after removal of cancerous; a large proportion of the subjects of the growth were alive five years and eighth months subsequently to the operation.

13. Of two deaths which followed removal of the tumor at the respective intervals of five and two years, the cause was accidental and not connected with the disease.

14. So far as we know, pure myeloid disease exhibits little proneness to recur after removal, there being only one instance yet recorded of that event (c 37); (*) but, then, in only half the cases collected is the subject of recurrence mentioned, and in many others sufficient time had scarcely elapsed to justify any opinion.

15. While medullary cancer recurs on the average in 7 months, and scirrhus cancer in 14, myeloid tumor in 18 instances, had not returned after an average interval of 26 months, and in 12 of these or two-thirds, the period of non-recurrence, was three years and five months.

16. Myeloid may exceptionally recur as myeloid both locally and in remote organs; the lymphatics enjoying immunity, and there being no cachexia.

17. It may co-exist in an external part, in the lungs and in a lymphatic gland, and even prove fatal without the presence of constitutional cachexia (c 39).

18. The same growth may comprise both myeloid cells and so-called "cancer cells," although in general appearance resembling myeloid tumors, and be succeeded by similar compound tumors in the lungs and spine, with marked cachexia (c 42.)

19. A tumor apparently myeloid, even on microscopic examination, may be followed after removal by genuine open cancer in the vicinity of the original tumor (c 41).

20. A tumor composed chiefly of fibro-plastic structure and partly of myeloid, may be attended with enlargement of the glands, and when removed, be rapidly succeeded by cancer at the site of removal and in the lungs, the glands though enlarged not being cancerous (c 40).

21. Of 42 examples of growths apparently myeloid, two of which, however, probably contained cancer cells, and one fibro-plastic elements; there were five in which the growth either recurred after removal, or had involved remote internal organs.

10 Bonaventure street, March 11th, 1859.

(*) I purposely have omitted some cases of myeloid disease of the maxilla which re-appeared after removal, apparently in consequence of having been only partly excised.

TABLE OF MYELOID TUMORS.

NO.	AGE.	SEX.	SITE PRIMARY GROWTH.	CAUSE.	SURVIVED 1ST REMOVAL.	SURVIVED 1ST DISCOVERY.	RECTARENUE.	DATE LAST REMOVAL.	AUTHORITY.	ARTICULATION ADJOINING.
1	18	M.	Head humerus.	Strain 3 mos. before appearance of tumor.	5 years.	3½ years.	None up to death, June, '68 of 1½ in. thick.	June, '68.	Mr. Simon and Dr. Britton, Path. Trans., vol. vii., p. 351.	Healthy.
2	23	F.	Head tibia.	None known.	Not stated.	18 months before pain felt over incision then extended gradually to head tibia and swelling perceived.	Not stated.	April, '66.	Mr. Jones, Med. Times and Gazette, Feb., '69, p. 172.	Disease had not extended into joint.
3	30	M.	Lower Maxilla.	None mentioned.	Not stated.	14 or 15 months when last seen removed.	None 2 mos. after operation.	Nov., '66.	Mr. Hutchinson, — 1/2, vol. viii., p. 386.	Not stated if healthy.
4	15	M.	Condyles femur.	Do.	Do.	{ 4 mos. when removed.	Do.	April, '67.	Mr. Thos. Bryant "	Unaffected.
5	.....	F.	Head tibia.	Do.	{ Died 10 days after operation.	Not stated.	Do.	.....	{ Sir B. Brodie and Mr. Gray, Med. Chir. Trans., p. 387.	Do.
6	18	F.	Head humerus.	Do.	{ Not known, survive 2 years afterwards.	Not stated.	None 2 years after.	.....	{ Do.	Do.
7	25	M.	Condyles femur.	Do.	{ Alive 6 years after.	{ 6½ years and then alive.	None 5 years after.	.....	{ Do.	{ Adhesions between articular surfaces.
8	30	F.	Head tibia.	After a fall.	Not stated.	Not stated.	Not stated.	.....	{ Mr. Lawrence & Gray, Med. Chir. Trans., v. 59.	Not stated.
9	25	M.	Condyles femur.	B'ow.	Alive 5 yrs. after.	Alive 6 yrs. after.	None 3 years after.	Dec., '64.	{ Mr. Cook and Dr. Wilks, Guy's Hosp. Reports, vol. iv.	{ Cartilage normal, nothing more stated.
10	33	F.	Do.	Fall on knee.	Alive 1 mo. after.	Alive 14 mo. after.	None for 1 month.	Sept., '66.	{ Do.	Do.
11	.....	.....	Do.	.....	.....	.....	.....	.....	{ Mr. Key and Dr. Wilks, Guy's Hosp. Rep., v. iv.	Not stated.
12	34	F.	Patella.	Blow.	Not known; left well.	Alive 2½ years after.	Not known.	Feb., '42.	{ Mr. E. Cooper and Dr. Wilks, Guy's Hosp. Rep., vol. iv.	Do.
13	Young	.....	Head tibia.	Not stated.	.....	.....	.....	.....	{ Dr. Wilks, Do.	Not stated.

TABLE OF MYELOID TUMORS.

No.	AGE.	SEX.	SITE PRIMARY GROWTH.	CAUSE.	SURVIVED 1st REMOVAL.	SURVIVED 1st DISCOVERY.	RECURRENT.	DATE LAST REMOVAL.	AUTHORITY.	ARTICULATION ADJOINING.
14			Do.						Do.	
15			Do.						Do.	Healthy.
16	36	M.	Head fibula.	No cause known.	Left in 1 month.	Alive 6 mos. after.	Not known after 3 months.	Nov., '56.	Do. Do. Mr. Cook and Dr. Wilks, Guy's Hosp. Rep., vol. IV.	Healthy.
17	27	F.	Acromion process.	None known; fell 14 months after-wards.	Alive 1½ years after.	(2 yrs. after tumor appeared, but symptoms 1½ previously.)	None for 14 years.	Jan., '56.	Do. Do. Do.	Healthy.
18	36	M.	Lower end radius.	None known; subject to rheumatism.	Died in 3 weeks.	7 months.	None.	Sept., '50.	Mr. Key, & Do.	Do. Do.
19	42	M.	Condyles femur.	Blow.	{ Alive 2 months after.	2 yrs. after blow.	None for 2 mos.	Dec., '58.	DRS. Butler and R. P. Howard, Med. Chronicle, March, 1859.	Adhesions between articular surface.
20	40	M.	Do.	Not stated.	Not stated.	{ Supposed between 2 and 3 years, but not certain.	{ Thought to have died of cholera (5 or 6 mos. after.	March, '54.	Dr. Scott and R. P. Howard, Med. Chronicle, March, 1859.	Healthy.
21	M.	18	{ Lower maxilla-symphysis.	Do.	Alive 6 yrs. after.	6½ years.	None for 6 years.		Mr. Stanley, Paget's Surg. Path., p. 490, Am. Ed.	
22	F.	21	Alveoli of superior maxilla.	Do.	Alive 2 yrs. after.	Alive 3 yrs. after.	None for 2 years.		Mr. Laurence.— <i>ib.</i>	
23	F.	23	Superior n axilla.	Do.	{ Alive about 2½ years.	{ Alive about 3½ years.	{ None for 2½ yrs after complete removal.	April, '51.	Do. Do.	
24	15	M.	Vault skull.	Repeated blows.		{ 3 years; died with head symptoms.			Mr. Stanley, Do.	
25	14	F.	Inferior maxilla.	None known.	Not stated.	Not stated.	None.	Nov., '42.	Lebert's Phy. Path., vol. II, p. 144. Do., p. 144.	
26			Do.							
27	23	F.	Condyles femur and shaft.	No cause.	Not stated.	{ Alive 2 yrs. after swelling noticed, and 2½ after pain was first felt.	Not stated.	Dec., '56.	Mr. B. Childs and Dr. Bristow, Path. Trans., vol. VII.	{ A few old adhesions between surfaces.
28	36	M.	{ Condyles femur, patella and head tibia.	Sprain.	{ 10 years and not said to be dead.	16 years.	None for 10 years.		Sir B. Brodie and Mr. Gray, Med. Chirurg. and Trans., vol. 39.	{ Disease had extended into articular surface.

29	F.	Condyles femur.	Not stated.	Not stated.	Not stated.	Not stated.	May, '54.	Mr. Ward and Mr. A. Adams; Path. Trans., vol. IV.	Healthy; except absorption of cartilage to extent of 3d.
30	M.	Condyles femur.	No injury.	Alive 10 years after.	Alive 14 years after.	None for 10 years.	1851.	Mr. P. Howitt.—76.	Not stated.
31	F.	D. major over proximal bone.	None apparent.	None apparent.	Died of pneumonia about 2 months after.	manifestation of head symptoms.		Lebert; Phy. Path., t. 2, p. 148.	
32	F.	About great toe; not in sole of bone.	None apparent.	Not stated.	20 years before removal.	Not stated.		Do.	
33	F.	Peroneum, lower part leg.	None apparent.	Alive 7 yrs. after.	Alive 11 years after.	None for 7 years.	Dec., '38.	Do.	
34	F.	Head tibia.	Appeared 2 mos. after an injury.	Alive 6 mos. after.	Alive 84 years.	None for 8 mos.	March, '59.	Mr. Shaw; Patholog. Trans., vol. VII.	Not stated.
35	M.	Lower end fibula.	None apparent.	Alive 9 yrs. after.	Alive 9 yrs. after.	None for 4 years.		Messrs. Parker, Paget and Gray; Medical Chir. Trans., vol. 30.	Do.
36	F.	Attached to lower end radius.	Do.	Alive 2 mos. after.	Alive 12 to 15 years after.	None for 2 months after complete removal.	Dec., '51.	Mr. B. Cooper; Med. Times & Gaz., Feb., 1852, p. 214.	Healthy.
37	M.	Head fibula.	Do.	(Alive 23 yrs died few days) after 24 removal (val of pleurisy 10 day when reported.	23 years after.	(2 yrs. after prot. removal, 3 myloid tumors in stump.	Nov., '58.	Mr. Cook, Dr. Wilks; Med. Times & Gaz., Jan., 1856, p. 71.	Cartilage perfect.
38	F.	Condyles femur.	Frequent blows.		Alive 8 or 9 mos after.		Jan., '59.	Mr. Simon and Sidney Jones.—76, Feb., '59, p. 171.	(Growth occupied joint, but cartilages intact

CASES OF A SOMEWHAT DOUBTFUL NATURE.

39	M.	Neck beneath sternum-mastoid.	None known.	Not removed.	1 yr. at autopsy.	(Died exhausted; 4 small myloid masses in lungs, and diffused in 1 bronchial gland.		Mr. Paget; Surg. Path., p. 454.	
40	F.	Head humerus.	Appeared 14 mos. after fracture and dislocation.	Lived 5 mos. after.	64 years.	(10 months after removal recurred as cancer at site of wound and in lungs.—Glands enlarged, but not cancerous.		Mr. Hutchinson; Path. Trans., vol. VIII.	Not stated.
41	F.	Mamma.	Not stated.	Died 21 months after.	64 years.	(6 months as open cancer of axilla.		Paget; Sur. Path.	
42	M.	Head fibula.	None known.	Died few mos. after.	(Operated on 6 mos. after discovery of tumor, and 24 yrs. after first occurrence of pain.	(A few months after operation myloid can. found in lungs and spine.	May, '57.	Mr. Cook & Dr. Wilks; Guy's Hosp. Reports, vol. III., p. 176, and vol. IV., p. 31.	Not stated.

ARTICLE XXIX.—*Cases of Alleged Poisoning.* By D. BERGIN, M.D.
Cornwall, C. W.

(Continued from page 404.)

{The discrepancy between the testimony of Dr. Dickinson and that of the lay witnesses, upon many important points, is so great, that I have prepared the following resume of their testimony, in my opinion necessary to a thorough comprehension of the cases. The lay testimony was *first* received. I append also the letter of the Coroner, over the signature of Maria Howell, to "Hoyt," of Syracuse, U. S., together with the answer thereto, and the Directions for taking the Medicine, sent therewith.)

William S. Wood, deposed:—I live in the house next to that occupied during their lives, by the deceased. They bore to me respectively, the relation of mother-in-law and sister-in-law. I saw the deceased about 5 p.m. of the day in which they were seized, neither of them appeared unwell. About 8 p.m., I passed their house and saw Sarah leaning with her arms upon the fence. When within about 15 or 30 feet from her, I asked what she was doing. She replied, very sick, in a very low voice, she then appeared to faint, and fell. I took her up and attempted to revive her, then called to my assistance Mrs. Forbes who lived in the next house. We together carried her to the door step. Mrs. Forbes sprinkled water over her face, but without any beneficial effect. I next sought my wife. I found her in bed, awakened her and brought her with me to assist her sister. We then awakened the mother, the deceased Mrs. Anne Jordan, who was asleep in bed, and told her that Sarah was ill. I then immediately went after Dr. Dickinson. Sarah *did not* complain of *pain* anywhere or give any indication of it. She never spoke again after fainting. Sarah did not vomit until after Dr. Dickinson gave her an emetic. What the vomited matter was like, I cannot say as I paid no particular attention to that, at the time. She was quite unconscious from the time I picked her up, did not seem to be at all benefited by the Doctor's treatment. He remained perhaps between two or three hours at his first visit, he did not return until the next morning. He said that from appearances, he thought Sarah was laboring under the effects of Poison. Dr. Rattery was called in, the morning after Dr. Dickinson left, he *did not* think that it was a case of Poisoning. Anne Jordan was taken ill while I was absent in search of Dr. Dickinson. Sarah died about 2 a.m. on Friday morning; her mother about 7 p.m. on Sunday following. About the end of the month of July last, at the request of Sarah, I went to the Grand Trunk Station for a Box, which she said, I would find there addressed to me. I obtained the box and

delivered it to her, of its contents I am ignorant. She did not tell me what was in it, altho' I put the question to her.

Lothrop Kendall, deposed:—I am Station and Express Agent at the Grand Trunk Railway here. On the 30th July I received a box to the address of W. S. Wood. I delivered it to him the next day. I saw nothing unusual or suspicious in Mr. Wood's conduct or appearance when he came for the box.

Eliza A. Forbes, deposed:—I knew the deceased, am no relation of theirs. I did not live in the same house with them, although we occupied the same kitchen in common. The health of the deceased was good up to their last illness, I saw them frequently during the day before they were taken ill. I saw them at supper. They ate oatmeal porridge for their last meal. I saw them cooking the porridge. After supper I saw Sarah again, she said she had made a very hearty supper of it. Her child also ate heartily of it. They took their supper before dark, before Sarah went to milk. I cannot tell what interval elapsed between the time they took supper and the time of their attack. I think it was about 9 o'clock, when W. S. Wood awakened me out of bed to help him with Sarah, who he said was sick. I found her lying on her back, on the green. She seemed to me to have fainted. She was insensible. I could not rouse her. Wood and I then carried her to the door step, where we kept her a little while, thinking she would revive more quickly in the air than in the house. Wood went for his wife before we took her in. After his wife came he went for the Doctor. Before taking Sarah into the house, we at once awakened her mother Anne Jordan to get the bed for Sarah. She was then asleep in bed quite well. After an opinion was given for Sarah, she returned for a candle, after obtaining which she came back and asked, what is the matter with Sarah? She then called for a chair to help us with Sarah, who lay with her feet towards the door, as she came near she fell. I cannot say whether she tripped or not, she lay perfectly still until we lifted her, she had no cramps or spasms, she did not seem to me to be in a faint like Sarah did at first. We put her to bed as quickly as possible. She seemed to me to breathe freely, but she moved one arm and one leg only, but on which side I cannot recollect. After being put to bed she vomited, but whether before or after the Doctor's arrival, I cannot say, the matter vomited was like oatmeal porridge. I did not see her vomit after the night of the attack, Tuesday. She lived until 7. p.m. of the Sunday following. Anne's children said on the night of the attack that she retained sufficient consciousness to squeeze their hands, but how long this continued I do not know. I cannot assign any cause for their

illness. I think Anne fell through fright caused by Sarah's state. I got a bowl full of the meal, from which the porridge they had eaten was made, and used it, I am sure it was the same meal. I was not the least afraid to use it. Sarah did not speak after being put in bed, nor did she vomit until after the Doctor came, when he gave her medicine, after which she vomited. The matter vomited was of a yellowish color, more slimy and less like porridge, I think, than what her mother vomited: it emitted no smell, whatever, nor did the matter vomited by her mother emit any smell. The deceased Sarah did not seem to be in the least benefited by the Doctor's treatment. Her feet was cold, and we put hot bricks to them before he came. She did not sweat any: she breathed very hard; her breathing was indeed hard enough; hard and rapid and strong, as if from the bottom of her belly. Her countenance was sometimes pale, sometime flushed, her limbs would remain in almost any position in which they were placed. Dr. Dickinson said they were poisoned. Dr. Rattray said they were not. Dr. Pringle also saw them before they died. I think he agreed with Dr. Rattray. He said that Sarah's illness was probably caused by going out into the cold, wet grass, barefooted, or something of that kind.

Cross-examined.—I do not know that Sarah Jordan took anything to cause her illness. Never knew anything bad about her. I did not hear until after her death that she had been pregnant, and not then from any one who could have known it had it been the case. I did not believe it when I heard it, nor do I believe it now.

Margaret Anne Wood, deposed:—I am daughter of the deceased Anne and sister of the deceased Sarah Jordan. They were taken ill on Tuesday the 17th August, Sarah died at 2 a.m. Friday the 20th; Anne on the evening of Sunday 2nd. Dr. Le witness here corroborated the most of Mrs. Forbes and Mr. W. [about] statement, her description of the matters, however, is more particularly given than theirs and we subjoin it.] Dr. Dickinson gave Sarah an emetic as soon as he arrived; she vomited just her supper, I saw it the next morning on the grass; it was nearly all oatmeal. My Mother vomited also, but not until after the Doctor's arrival, although she seemed sick at her stomach before he came. My mother and sister, which had a motion of the bowels during the night. My mother breathed very easily, without any distress; Sarah, on the contrary, breathed very hard, I heard her breathing before I got to the house. Dr. Dickinson said they were poisoned. At his second visit he repeated his opinion more positively than at his first, he said what they were vomiting was alike; that it looked glary, like slippery elm Tea. Sarah's vomiting was, I think, more like this

than mother's, for we were frequently obliged to remove sticky sort of stuff upon her mouth with a cloth. Dr. Dickinson said he remarked a peculiar smell from the vomited matters. I did not, I thought it was from the purging. I do not think any one beside Dr. Dickinson noticed any odor from the vomiting. Dr. Rattery when he came said that they were not poisoned; he said my mother was laboring under one of her old attacks; he had attended her three time for Paralysis. Dr. Pringle was also called. He agreed with Dr. Rattray that they were not cases of Poison. After Sarah's death, I found a bottle and a box of Pills in her box. I gave them to my brother-in-law, John Barlow, to take care of in the event of an examination, as he thought there would be one. I paid no attention to the bottle or pills myself. I thought nothing of them.

John Barlow, deposed:—I am son-in-law of the deceased Anne Jordan, and brother-in-law of the deceased Sarah. I was sent for to see them about 11 p.m. on Tuesday, 17th August, I went immediately with my wife. We found Dr. Dickinson there when we arrived, he was about to give an emetic to Sarah, who was unconscious; the old lady was vomiting at the time. Sarah breathed a great deal harder than her mother; she was yawning once and a while, snoring and puffing as she breathed, there was froth about her mouth; it was slimy, and they removed it with a cloth or handkerchief. I did not notice any odor from the matter vomited by either of the deceased. Dr. Dickinson left before I did. I saw him examine and feel the pulse of Sarah, but I did not see him examine her mother. He may have done so before my arrival, *but not after*. Drs. Rattray and Pringle were afterwards called they did not agree in opinion with Dr. Dickinson. They thought the old lady's case was one of Paralysis. Dr. Rattray said that he thought Sarah's was Congestion of the Brain. After the death of Sarah and before the death of her mother, the house was searched and this phial and box of pills which I now produce were found in a box of Sarah's. I did not think they contained poison, but preserved them in the event of an investigation, in consequence of Dr. Dickinson's opinion that they were poisoned.

Cross examined by Dr. Dickinson.—I recollect that Dr. Dickinson said, at one time, there was a decided improvement in Sarah, *but nobody else said so. She did not revive, nor was she able*, as he states, unassisted to raise her head after the action of the emetic. I was told to bring here the phial and pills by W. S. Wood, he called on me on Monday morning last for that purpose. I did not understand Dr. Dickinson to advise an investigation. There was no suspicion of Sarah Jordan being pregnant.

Mary Barlow deposed :—" I am the wife of the last witness, a daughter of the deceased Anne Jordan, and a sister of the deceased Sarah Jordan. I was sent for in August last, on a Tuesday night, to see my sister Sarah—she died on the Friday following, the 20th. I found my mother and sister, both speechless and unconscious. My mother after being bled by Dr. Rattray showed signs of consciousness. She would squeeze my hand, and continued to do so, occasionally during two days. She could move her left leg and hand slightly up and down but her right side was completely paralyzed: her right eye was open the greater part of the time, and both eyes shortly before she died. The health of my mother and of Sarah was good as usual before their attack—at all events I never heard any thing to the contrary. I cannot say whether Sarah was regular or not. I do not know any thing of the box received by W. S. Wood, by Express. I never heard of any such box before Monday last. I have no idea whom it was for, what it contained, or what became of it. The bottle and pill box, before the Jury, were found in a chest, not locked—both Sarah and her mother could have access to it. Dr. Rattray said as a post-mortem examination might be ordered, I ought to preserve the clothes, in which Sarah and my mother vomited.

By Dr. Dickinson, through the Coroner—" I have not heard it said that Dr. Dickinson said they were poisoned so that he might hold an inquest, nor did I say so myself. I heard no remark made by Dr. Dickinson as to the odor of the matter vomited. My mother had attacks of the same kind, but not so severe, four times previously, within five years. Dr. Rattray attended her. She always lost the power of her right side in these attacks, sometimes for three weeks or more, but she was not always entirely unconscious. In the interval, between the attacks, she complained occasionally of giddiness, but not of pain, and seemed to be pretty well, considering. She always vomited in these attacks, as in the last fatal one, and would continue vomiting some time. I noticed very little difference between what Sarah and mother vomited. Sarah's was perhaps more rosy, but mother had nearly done vomiting when I arrived."

By the Coroner—" The cloths in which she vomited are still in the house in which she died—they have not been washed."

I did not see Dr. Dickinson examining my mother, he did not feel her pulse or do anything of that kind while I was in the house. He may have before my arrival. I saw him approach her bed; his hands under his coat tails, he then said they vomited matter much alike, and walked back again to see Sarah. I did not hear him say anything about their being a peculiar odor from the matter vomited. I am positive that he

did not feel her pulse or clasp her hand, while I was in the house. I remained there after he left.

Mrs. W. S. Wood, re-examined, deposed;—I did not see Dr. Dickinson make any examination of my mother, he did not feel her pulse or lay a hand on her. I do not think Sarah had an abortion; I do not think she could have had without my knowledge for we were more than half of our time together, I threw the matter vomited out on the grass. I saw it in the morning; it was *all outweal* and the hens were eating it.

No. 1.

DICKINSON'S LANDING, Nov. 23rd, 1858.

Dr. Hoyt, Syracuse.

SIR,—Will you be kind enough to send me a parcel containing the same articles you sent addressed to W. S. Wood, Cornwall, July last. I am very anxious to have it sent without delay, by Express. Address James H. Stewart, Inn Keeper, Dickinson's Landing Dep't C. W., who will pay the charge on delivery. Now Doctor, I hope you will not refuse it on account of my not sending the money in advance which I certainly should have done, but did not see the lady for whom this medicine was intended only just long enough to find out when she obtained it and that it had the effect anticipated. If you feel doubtful in regard to the pay, direct the express company not to deliver it until all charges are paid. By sending it immediately you will relieve me of the greatest anxiety.

Yours, etc,

MARIA HOWELL.

No. 2.

SYRACUSE, Nov. 6, 1858.

MADAM,—Your letter is at hand. Enclosed find medicine to bring on a miscarriage. Follow as directions with it. If you have gone too long for the medicine to affect you, and you want an abortion produced, I have an *Instrument* that I use, that is perfectly safe and sure and will make you all right in 24 hours. You can come to me and stay a week and go home all right, or I will come to your place and use it. Ladies come to me from all parts of the States to have the *operation* performed.

Be so kind as to write me how the medicine affects you.

I am,

Yours respectfully,

WM. E. HOYT.

P.S.—Be sure and direct your letter to Wm. E. Hoyt, for there is others by the name of Hoyt in this City.

No. 3.

DIRECTIONS.

In cases of suppressed or painful menstruation take a teaspoonful of this Medicine 3 times a day, twenty minutes after eating. If it should produce nausea, it may be taken in half a teaspoonful of water. Soak the feet in warm water, and drink freely of Pennyroyal or Tansy tea, as warm as it can be drunk. While taking this Medicine, the most suitable time for taking the "AMIE DE FEMME," is three or four days previous to the time for the periodical turns. Pregnant females are cautioned not to use the Medicine, as it will produce certain miscarriage. Shake the Medicine well before using.

WM. P. DUMAS.

To the Editors of the Montreal Medical Chronicle.

GENTLEMEN,—In Dr. Bingham's remarks appended to Dr. Brow's account of his own illness, there is a reference to my experience of Dr. Kerr's medicine in dysentery.

The reference is chiefly to my sister's illness, which was so alarming, and the cure so wonderful, that I may be excused for attempting to obtrude my non-professional opinion of its merits upon your valuable journal.

My sister (a person of very general delicate health) was seized with diarrhoea in September last, which gradually changed to dysentery. In about a week the discharges became profuse and frequent, and I do not exaggerate when I assert that several exceeded half a pint of clotted blood in quantity. The profuseness of the discharges and their frequency brought on most alarming symptoms. The limbs were becoming cold, and covered with clammy perspiration; the pain was likewise intense, with frequent vomiting.

I could now only entertain the most serious apprehensions of a fatal termination to the disease, having often seen men under my command in India cut off by, in my opinion, less severe attacks, the efforts of the medical gentlemen too frequently proving powerless to arrest its progress. I had heard that the terrible and nearly uncontrollable dysentery of our army in the Crimea had exhibited the same characters as those now before me, viz., intense pain, and frequent discharges of blood.

Fortunately, I had some of Dr. Kerr's Medicine beside me, and at once gave a small dose—perhaps $3\frac{1}{2}$ grs., not more; relief speedily followed, which lasted a few hours. A second powder of the same size was again given, with a similar good effect. Gaining confidence from

the benefit, unalloyed with any mixture of evil. I gave a third powder somewhat larger than the former, when the relief was complete.

It may be too marvellous to be credited, nevertheless it is perfectly true, that this alarming illness was cured by these three doses without any other remedy, except a gentle laxative a few days afterwards.

ROBERT CAMPBELL.

East Zorra, C. W., 1st March, 1859.

REVIEWS.

ARTICLE XXX.—*A case of Aneurism of the Right Femoral Artery, cured by Digital Compression; with remarks, and a statistical report of 22 other cases, treated by this method.* By SAMUEL W. GROSS, M. D., chief of the Surgical Clinic of the Jefferson Medical College, Philadelphia. Philadelphia: J. B. Lippincott & Co. 1859. From the Author.

Dr. Gross here presents the reader with the narrative of an interesting case of Aneurism occurring in Scarpa's triangle, which he very successfully cured by compression, exercised by the fingers of himself and several assistants. This style of compression has in his words the following advantages over the same method when conducted by the assistance of mechanical contrivances, as the instrument of Carce, &c.; "it is quicker and less painful, it can be regulated better, and in some situation can be made to act upon the artery alone; it is applicable when apparatus is not, and in cases in which mechanical contrivances cannot be borne it can be used to excite a tolerance of the skin previous to their employment."

The total amount of time expended in the treatment in Dr. Gross's case was 45 hours and 55 minutes. The compression was steadily maintained for 41½ hours from its inception, it was then intermitted for about 17 hours or a little more, and upon being resumed was continued 14 hours and 35 minutes longer. It was so applied as to prevent the blood from entering the tumor, with the exception of two hours during which a slight current was permitted to flow through its interior. The case was perfect, the issue most satisfactory. Dr. Gross, with much industry, has collected the histories of the various cases, which up to the time of the occurrence of his own, have been recorded. They number in all 22, and he has given a brief analysis of the leading features of each, which he appends for the information of the reader. The details also are interspersed with various explanatory observations tending to enrich materi-

ally the value of the communication. Dr. G. bids fair to prove a worthy successor to the deservedly honored Professor S. D. Gross, whom we heartily congratulate in having the enjoyment of so promising a descendant, upon whose shoulders may fall his distinguished professional mantle.

Dr. Gross concludes his remarks with the following propositions :

I. Digital compression, uncombined with apparatus, was first attended with success in the hands of Dr. Knight ; but to M. Vanetti is due the merit of having first introduced it into practice.

II. It has never been followed by bad consequences, and when not successful, it so modifies the tumor and the collateral circulation as to render a cure by the means almost certain.

III. It has been employed alone, either previous or subsequent to mechanical compression, in fourteen instances, eight being failures.

IV. In only seven cases have it been employed primarily and alone, and in all but two with perfect success.

V. When double and alternating, it has effected cures in every case, five in number, and therefore deserves special attention.

VI. In most of the cases the compression has been total ; but this is not necessary for a favorable result.

VII. It has effected cures, whether it was continued, interrupted, or intermittent ; in some cases the patient applying the pressure.

VIII. When properly employed and continued for a sufficient length of time, and the cases are suitable ones, it can scarcely fail to accomplish a cure. Inguinal aneurisms are not fit cases for this procedure.

IX. It is less apt to give rise to inflammation of the integument, and has been borne when mechanical pressure has produced an eschar.

X. It can be used when apparatus has failed or is intolerable. In a majority of these cases, cures have been accomplished.

XI. In certain situations it can be made to bear upon the artery alone. It is far less painful and requires a much shorter time for a cure than any other method of treatment."

CLINICAL LECTURE.

(From *London Medical Circular*.)

On the Operation of Puncturing the Bladder in aggravated cases of Retention of Urine. By FRED. C. SKEY, Esq., F.R.C.S., &c., Surgeon to St. Bartholomew's Hospital.

GENTLEMEN,—I have selected for practical consideration to-day a subject of particular importance to you as surgeons, one indeed that you will hereafter be liable to be called upon almost at a moment's notice to decide, and to decide, as I may say, in a manner that may involve the

question of the life or death of the patient; it is a subject too, if ever there was one, that involves matters of pure surgery, and nothing but pure surgery. The matter in hand is, therefore, eminently practical; it is useful rather than ornamental. I am not choosing something for you out of the common, such as tying a ligature on the aorta, an operation I hope you will never be called on to attempt, nor I either: nor is it resection of the acetabulum or knee with pathological antopsies and all the rest of it; no, it is the simple subject of tapping the bladder in retention of urine.

Now, you all know perfectly well what retention of urine means, so I need not go, as is customary, into any learned definitions. Perhaps, we will say it is "a condition of things in which there exists an inability of the bladder, to get rid of its contents;" that will serve for a definition as well as anything else. No one with his senses about him now confuses retention of urine and suppression,* so we need not dwell on the good old diagnostic marks of the books that you read on that point; then incontinence of urine, of course, we have nothing to do with.

Well, so much for that. I think if I read you the case, which forms the text, as it were, of the present lecture, you will be able to follow me better.

A man, aged fifty-two (in No. 8 bed), described as one of the better sort of cabmen, in rather good circumstances, was brought to the hospital in Christmas week. We are told by himself that, for a period extending over something like eighteen years, he had had slight symptoms of stricture, but prior to his admission to the hospital he never had had severe retention of urine, or anything at all like his present suffering from inability of the bladder to expel its contents. Well! the house-surgeon tried in vain to pass several instruments; warm baths and warm fomentations to the hypogastric region were tried; catheters of various kinds; small doses of opium; hyoseyamus, &c.

30th.—Attempts made with various catheters; he was ordered hot bath again, and to have tinct. opii 40 drops; the swelling of the hypogastric region is very considerable.

31st.—Twelve o'clock.—I ordered opiate enema of starch in a very small quantity, so as to be retained in the rectum, and about a drachm of tinct. opii. Two o'clock.—I saw him again and eight ounces of urine has come away under the relaxing effect of the opium, which was directed to be continued as well as the fomentations, &c. Eight o'clock.

* Suppression of urine means an interruption of the secretion of that fluid none being formed or discharged; examples of this affection were very common in the cholera of late years.

—twenty-four ounces had passed, and towards eleven o'clock thirty-one ounces had come away.

January 2.—You see I pass over a day here, during which the opiate treatment and the trials with catheters got free and fair play. I was sent for this day to perform some operation as there had been complete retention for twenty hours. It was now a question of performing perineal section, the operation known as Mr. Syme's, or whether we should puncture through the rectum. I decided on the latter, for reasons that I shall detail to you presently.

Whilst on the operating table some few ounces of urine trickled away, but as retention to such an alarming extent had followed the trickling of urine on the 30th, what guarantee had I that the bladder would not play the poor man the same trick again? I thought it better not to alter my scheme so I proceeded to operate.

The operation of puncturing the bladder through the rectum was performed; it is of course nothing as an operation, but the relief to the poor man was most satisfactory. An assistant makes slight pressure on the pubis; a curved trochar, with its point drawn within the cannula, is kept exactly in the central line of the front portion of the rectum, and beyond the prostate pushed into the bladder behind the line of reflection of the perinaum. Well, so much for the case.

We read next, that on January 13 all went well. The urethra, in fact, has had a holiday, as Mr. Wormald calls it, and the man left the hospital all right.

Now, what is the nature of this case? Is it to be supposed the slight symptoms of stricture which he complained of prior to his admission to hospital, and which had continued for a period of something like eighteen years, had gone on slowly increasing up to the day of the sudden seizure of retention? No, I think we should be wrong to decide the question in that manner. You know very well that the urethra contains in its tissue underneath its mucous membrane a very considerable amount of muscular fibre. This I have recently had occasion to demonstrate for you. The quantity of urine passed by this man under the relaxing effects of the opium is evidence also of the fact of muscular spasm in a more homely shape. It is a fact now admitted by the best surgeons that almost all cases of stricture at a certain age, like that in this case, are spasmodic, depending on local irritating causes. This poor man had been probably making merry after Christmas, and had taken an excessive amount of gin or porter, followed by chills or wettings; perhaps if we said that almost all cases of stricture are partly organic and partly muscular, we should not be far wide of the mark

All this you must remember, qualifies the after-treatment most materially. Thus a man, with these unenviable shoals and quicksands in his urinary passages—we'll say Mr. X. Y. Z., who to-day allows a No. 6 or No. 5 catheter, but goes to-morrow—we'll say to a public dinner—where there is turtle and punch, and comes home in a damp cab, will not allow a No. 4!—all according to the condition of the muscular layer of his urethra, and excess of drink he has indulged in.

These cases of retention vary exceedingly. If I were to divide them into classes it would be according to the "ages of man," as Shakespeare has it; first, the infant or young child, and the retention so peculiar to that age—the retention from congenital phimosis, or from stone in the bladder so familiar in hospitals; next the retention of early manhood—namely, that of spasm without stricture. A young man goes to a drinking party, or such places as oyster cellars, and gets intoxicated and chilled. The age after this is that of our patient in the present instance, aged 52; mark his own description: that for a period extending over eighteen years he has had slight symptoms of stricture without actual retention; he too makes merry, and drinks too much at Christmas. Then you have the combination of muscular or spasmodic and organic stricture and frightful retention of urine. Another class of cases are the inveterate strictures that go from hospital to hospital—poor patients who have had all sorts of surgical devices demonstrated on their perineum; then

"Last scenes of all

That ends this strange eventful history,"

we need only name the retention of old age from prostatic disease. This often takes the form of incomplete retention. The bladder in old people loses tone, its contractile power is lost, and the urine dribbles away in small quantities, and we have second childishness and mere oblivion!

I hear sometimes of enigmatical cases of stricture of an organic kind, the patient being 18 to 20; but you may depend on it that there is no such thing as stricture of an organic form at this age, except from direct injury of the perineum—as, for instance, a boy sometimes falls astride on a gate or branch of a tree, and injures his perineum and urethra; but there is no more reason to believe in organic stricture in a young man, aged 18, than that prostatic disease is common at 40; no, as a general rule, *par excellence*, the age for organic stricture begins at 30 and ends at 50, and spreads over these twenty years pretty equally.

Treatment of Retention—Ay, there's the rub! What are you to do in cases of obstinate retention? Your patients comes to you in the

deepest suffering; you feel the outline of the distended bladder over the pubes, even as far the umbilicus, or in private practice you are hurried away perhaps in the middle of the night, and find him at home. Various remedies having been tried and found of no avail, he is anxious for relief in any—the most speedy way; he is in the utmost torture; he thinks the viscous may give way; but this, I may say, seldom or never occurs in the popular sense. Well, you are all this time feeling the fluctuation of the abdomen and the distended outline of the bladder; but mark well, also, the age and previous habits of your patient, and that there is hot, dry skin, thirst, and accelerated pulse; you examine the perineum: you ask what already has been done in the way of opiates, diuretics, &c. &c. You feel next in the line of urethra all the parts in front of the triangular ligament; if there be no induration of the corpus spongiosum of the urethra, and the age of the patient is favourable the case is not likely to be severe, and I should continue to press the catheter that you have been working with all this time steadily onward; you need not be afraid of lacuna if you keep the instrument against the upper side or surface of the canal—*don't use force*—mind you manipulate properly; thus the point of the catheter may be stopped, not by a lacuna, but by a fold of mucous membrane doubled on itself as it were; in this case you draw forward the penis on the instrument and very probably it passes. I think it as well to say, however, that, notwithstanding all care and all our precaution, a false passage sometimes is made; thus I was engaged in a case once along with admittedly the first surgeon in the empire; the instrument was urged on by him, and a false passage made!

Chloroform—how about that! Some surgeons that I meet at the College are in favour of chloroform; my experience of anaesthetics I must say is small, but my experience of opium is large, and I would say try opium by all manner and means, especially opium in the rectum.

A double quantity of opium in shape of enema is to be used and thrown into the rectum with about two ounces of starch, not more. [By the way I use the term enēma, not enēma, the second syllable is short not long; perhaps I should apologise to my friends who know their Greek, but Archdeacon Paley is known more for his one false quantity than all his sermons.] If the enema acts and you foment the bladder, the patient will go to sleep, and then when he wakes up it will be perhaps to pass some water or to allow some further progress to be made with the catheter. If you fail in everything as in this case last Christmas, what are you to do? I believe you have no other resource but to puncture the bladder. There are, of course, three modes in which this may be

effected, viz., through the membranous portion of the urethra, through the rectum, or above or through the os pubis. The operation above the os pubis is out of the question, though Mr. Abernethy rather liked it, and bungled the perineal performance; then there is the "perineal section," as it is called, adapted to obstinate stricture cases, and there is what I conceive is the best operation of the lot—the operation of puncture of the bladder through the rectum; for mind you, the object you must have in view is to relieve the bladder by the speediest method, not to cure the stricture; nay, more, there is no doubt that if you at once relieve the *vis a tergo*, you in the same measure tranquillise the part of the urethra at the seat of the stricture, you leave the track of the urethra, in fact, through your puncture through the rectum, in a better condition for dilatation by instruments. Sir C. Bell and Sir Astley Cooper thought highly of an operation which consisted of an incision into the dilated membranous portion of the urethra; but we are now concerned with what I think the best operation, that through the rectum.*

Now, in the present case I punctured through the rectum, and for this reason, which I wish you to note particularly. I punctured through the rectum *as this is the best operation where there is no old standing stricture present of an organic kind, but if organic stricture be present then Syme's operation is the best.* I punctured the bladder, in short, as for a period of eighteen years the man did not suffer very much from his symptoms, and if the urethra and its muscular and mucus track obtained rest for a fortnight. I had every reason to hope it would, at the expiration of that period, resume its healthy tone, or at least that we could resort to the use of bougies (the most approved plan of treatment), with a fair share of success. Now see the difference; if this man had old organic stricture, of a bad kind, with frequent fits of retention, induration in the track of the urethra, in front of the triangular ligament, &c. &c., what promise could I hold out to him that he would not be again seized with "retention" as soon as he left the hospital by a mere puncture through the rectum. No, here we must fall back on the operation brought favourably into notice by Mr. Syme. The curative plan I have adopted in this case, I may say in conclusion, is one of the simplest in surgery; you must take care only to keep in the mesial line of the rectum; the bladder in these cases bulges down. if my eyes were blindfolded I

* A man appeared in the out-patients' department recently at St. Bartholomew's, to have a catheter passed; he seemed in excellent health, and showed the mark where he had been operated on at the os pubis many years ago, by Mr. Earle. Mr. Abernethy once tried this operation, but the trocher did not enter the bladder at all!

could tell the feel of the distended bladder beyond the prostate; take care not to let the canula slip out as you must puncture again if it does.* Mr. Cock and Mr. Hilton, of Guy's, two most able surgeons, strongly recommend this operation. I entirely endorse their statements. Keep the patient's bowels free, and a clever nurse can manage to keep the canula in the rectum all right during defecation; things improve wonderfully in the peccant parts of the urethra.

While the bladder is relieved through this artificial channel this is your time to try the plan of Sir B. Brodie, the best of all plans, in place of iron tubes and guides. I mean the plan by a seven or six wax bougie to dilate the urethra. Hold the bougie at first in contact with the stricture; then twenty-four hours after try it again and you find it goes down farther and farther. I don't know anything of chloroform in these cases† but you may adhere, as we did in our patient, very firmly to the wax bougies; for when he left the hospital the report says a No. 9 instrument was readily passed. I hope the gentleman who drew up the case with such graphic skill, zeal, and assiduity will excuse me if I say that this was rather overshooting our mark in these times of long-range guns. I would have been better pleased with a No. 7 or No. 8; I should be afraid that a No. 9 would distend the urethra a "leettle" too much; for mind you when the man came into hospital we could not pass any instrument at all, even the smallest. No doubt his urethra has once more recovered its tone and is now in a better condition than if we had rushed at hazards to open it by PERINEAL SECTION.

----- THERAPEUTICAL RECORD. -----

Perchloride of Iron.—M. Vigla relates a case of very obstinate catarrh of the bladder, brought on by the permanent retention of an instrument in this organ, when the subject of paralysis. Various means had been tried without mitigating the affection, which also now had become complicated with severe hemorrhage, and all its attendant ill effects. Very speedy relief soon followed

* This occurred at St. Bartholomew's, in the practice of another of the surgeons; it is a very awkward accident. The patient died with the punctures in his bladder.

† In a case of bad stricture of this kind last month at University College Hospital, Mr. Erichsen after failing in all sorts of instruments, as the stricture was very tight and perceptible in the perineum, placed the man well under chloroform, which is his usual custom; the stricture was then relaxed but very slightly. A straight urethrotome (not Civiale's, which did not answer) was next passed easily into the stricture, a notch made, and this able and indefatigable clinical teacher had the satisfaction of passing down a No. 8 before the man left the table. The whole thing did not take five minutes.

the use of the perchloride of iron, in doses of a spoonful twice a day of a mixture composed of 12 parts of the perchloride to 250 parts of water.—*Journal de Pharmacie*.

Argenti nitras in oxyuris vermicularis.—By D. C. H. Schultz.—The author ordered enemata of argent. nitr. crystal. grs. x-xv., to aq. distil. $\bar{\text{z}}$ iv., and cured his patients with two or three injections of this kind, completely, and without trouble. The first injection does usually not remain long, and with it many partly dead, partly live worms, are discharged. The subsequent clysters, however, remained six to twenty-four hours, and a great number of dead worms were evacuated with them.—*Deutsche Klinik*.

Cerate of Opium in Carbuncle.—By Dr. W. Von Gutzeit.—A cerate containing one-half drachm of opium to two ounces of simple cerate, is spread thickly upon linen, and applied to the swelling and its neighbourhood. This application diminishes pain quickly, generally in about half an hour, hastens suppuration, the detachment of the slough, and the cicatrization of the suppurating surfaces, and ameliorates the general condition of the patient. No medicine was given internally. The opiate cerate can be used at any stage of the disease, and its curative effects seem to surpass that of every other known remedy.—*Medic. Ztg. Russel.*—*Schmidl's Jahrbücher.*—*N. Y. Med. Chir. Rev.*

Dental Neuralgia.—Acetate of morphia 1½ grains, acetic acid 2 drops, and eau-de-Cologne ℥ ij. M. Balloy states that a little of this mixture placed in the ear in cotton, in the ear on the same side as that in which the dental neuralgia prevails, is of remarkable efficacy.

Croton Oil as an Epispastic.—M. Von Bastelaer, of the Antwerp Military Hospital, has contrived the following formula:—Recent lard 22, white wax 2, and croton oil 6 parts by weight. Melt the wax and lard by a gentle heat, and rub up in a heated mortar until the mass becomes cool, and then mix in the oil intimately. This pomade proves very useful when the influence of cantharides upon the urinary passages is feared.—*Bulletin de Therapeutique, tome 55, p. 415.*

The Electric Cutlery in Obliteration of the Nasal Canal.—Dr. Restelli states that he has found cauterisation by electrical heat an effectual remedy in several cases of obstruction of the nasal canal which had resisted various modes of treatment, the cure being both rapid and durable.—*Annales d'Oculistique, tome xl., p. 91.*

Camphor Ice.—This substance, which is a very delightful thing to rub on the exposed parts of the person, to prevent chapping and sores from cold, is made as follows:—Take one pound of almond oil, one pound of rose water, one ounce each of wax and spermaceti, two ounces of camphor, and one ounce of rosemary. Melt the camphor, wax, and spermaceti in the oil by a gentle heat, then add the rosewater, stirring briskly or rubbing in a large mortar, and lastly, the perfume. The consistence may be varied by increasing or diminishing the proportion of wax and spermaceti.

Solution of Sulphate of Quinine.—A correspondent suggests that the want of exactly proportioning the sulphuric acid to the quinine to be dissolved, is sometimes a source of mischief, owing to the excess of acid present; and he proposes that other acids of a more inoffensive character should be employed. Thus, citric acid will effect the solution of an equal weight of quinine.—*Rev. Med. Aug., p. 247.*

PERISCOPE.

Relative value of the different Anthelmintics in the Treatment of Taenia.—Dr. Peacock states, that as a general result of his experience, both in public and in private practice, he prefers the oil of male fern to all other remedies, and that he holds the kousoo in very light estimation indeed. It appears that of the hospital cases respecting which notes have been preserved, the fern oil was given in thirty five. Of these, in sixteen no other remedy had been previously tried, and in this group the result was always satisfactory, the animal being expelled in a dead or dying state. In seven cases the oil was given after the partially successful use of kousoo, and in all these more of the worm was brought away. In three, after partial success by pomegranate bark, the oil brought away other portions of the parasite, and in one a like result was obtained after the use of the turpentine draught. In six cases in which the oil was used, either the result was not satisfactory, or the patient did not attend again. The dose of the oil given was from half a drachm to a drachm and a half to children, and from a drachm to three drachms to adults.*

The cases in which kameela was given are seven. In five of these no other remedy had been previously tried, and in all these, portions of worm (generally quite alive) were expelled. In one, the expulsion of worm was caused after kousoo had been tried without effect, and in the fifth, which was under similar circumstances, a like negative result followed its use also. In two cases, after the successful employment of the kameela, the oil of fern was employed without procuring the expulsion of any more of the worm. The dose of kameela prescribed was from half a drachm to a drachm for children, and from one to three drachms to adults.

It would from the above facts appear, that kameela is more efficient than kousoo, but that it must rank as a vermifuge rather than a true vermicide. After the fern oil the animal is usually voided dead. An important statement with regard to the comparative value of kameela is made by Mr. Henry Calaway, formerly of Finsbury-circus, but now a medical missionary among the Zulus. The kameela is the native remedy among the Aborigines; but in a letter to the *Pharmaceutical Journal*,

* We are informed that great care is necessary on the part of the dispenser, in order to avoid disappointment on the use of the oil of fern. Its ethereal solution, which is by far its best preparation, of standing, deposits its resinous principle. A prolonged shaking is necessary to secure readmixture. Unless the dispenser pay more than usual attention to this matter, the patient is very likely to get a dose which is but little more than ether.

Mr. Callaway states, that from experience they have learned already to put much more confidence in "the white man's dose." The latter consisted in turpentine and castor oil, the time honored remedy among ourselves. We are not able from Dr. Peacock's cases, to institute any comparison between turpentine and the fern oil, and can only state that we believe he is supported by several other hospital physicians who have given much attention to this matter, in maintaining that the latter ought to stand *facile princeps* among our anthelmintic drugs.

As regards the economies of the question, which are important in hospital and Union practice it will, of course, be easily granted that all things considered, the most efficient remedy will probably in the end prove the cheapest. A dose of castor oil and turpentine, undoubtedly, costs far less than any of the others. Next to it comes the koussou, which has as rapidly fallen in price as it has in general estimation. The kameela is, as yet, rather expensive, though not nearly so much so as the fern oil. A full dose of the last costs eight-pence, of the kameela about four-pence, of the koussou three-pence, and of the turpentine and castor oil not more than three half-pence.

Kuchenmeister, in his *Manual on Parasites* (Sydenham Society's edition), writes of the oil of turpentine, as follows: "As has already been remarked, the touchstone of a remedy for tapeworm is not whether it expels *bothrioccephalus latus* or *tenia solium*, but whether it is also capable of effecting this with *t. medice-cantabata*. That oil of turpentine is efficacious in the latter case, I can prove at any time; for the finest specimen of *tenia med.* that I ever saw was expelled by it. In general, also, it acts pretty rapidly. Lastly, it has also the advantage, that it expels the worm entire." Of the koussou he writes, "For my part, I have always been more or less unlucky with this remedy . . . I have generally seen the worm expelled in innumerable fragments. . . . I have never found the head. In one case I detected fragments in the evacuations for three months." Professor Martius, of Erlangen, who has also used koussou largely, never saw the head brought away. Of the male fern. Kuchenmeister states, "This remedy, which will always maintain its renown against the *bothrioccephali*, appears hardly to maintain its reputation with regard to *tenia*." The kameela he had of course not tried.

Of the desirability of having the intestinal canal as empty as may be before giving anthelmintics, most practitioners are aware. To administer them fasting in the morning is usually thought sufficient, but in cases where difficulty has been encountered in destroying the animal it may be well, as an introductory measure, to give it a sharp purgative.—*Med. Times and Gaz.*, Nov. 6th, 1858.

Tartar Emetic in Large Doses in the Treatment of Chorea by M. GILLETTE. In the session of March 6th, 1858, of the "Société Médicale d'Emulation," M. Gallard mentioned a thesis of M. Bonfils on the use of tartar emetic in large doses in the treatment of several cases of chorea. As the facts reported in the essay of M. Bonfils had been observed in the service of M. Gillette, the latter was requested to explain to the Society his mode of treatment. It is the following:

For the first day he prescribes ten centigrammes of tartar emetic, which the patient takes from hour to hour. In the course of the day vomiting generally supervenes; if it becomes too frequent, the medicine is taken less frequently, or is entirely suspended. On the second day he prescribes twenty-five centigrammes; this produces, perhaps, some vomiting still. On the third day, thirty centigrammes; this is generally *not* attended by vomiting or purging. After this period, three or four days rest. There is already an improvement, and a perceptible amelioration of the disease. In exceptional cases, the cure is obtained thus early. The patient is subjected to the same treatment for another period of three days, during which M. Gillette prescribes progressively, twenty-five, fifty, and seventy-five centigrammes of tartar emetic. This period is also followed by three or four days of repose, after which the dose of the medicine is pushed to thirty, sixty, and one hundred grains. The improvement is such, that no disorderly movements are any more perceived. The case may then be confirmed by ordinary means, particularly gymnastics and sulphur-baths; but this is a precaution dictated more by custom than necessity.

Since the thesis of M. Bonfils, several new facts of cure have been observed. The use of tartar emetic in the treatment of chorea has afforded to M. Gillette actually thirty-seven cures and only one failure in thirty-eight patients submitted to his observation. The author's attention in the administration of the medicine is particularly directed toward establishing, as soon as possible, a tolerance of the remedy; perturbation of the system, by producing the violent physiological effects of the emetic, should be avoided. The chorea disappeared progressively, and the sooner, the more intense the affection had been.

M. Brienne de Boismont reports a case cured in five days by the method of M. Gillette.

There was nothing said of the local action of tartar emetic on the mucous membrane, and it is well known that the prolonged influence of the medicine has some inconveniences.—*Union Médicale*, June 12th, 1856, and *North Amer. Med. Chirur. Review*.

The Cessation of the Elimination of Odors a sign of Bright's Disease.
 —M. De Beauvais read a paper on the "Deficient Elimination of Odorous Substances through the Urine in Bright's Disease," at the meeting of the Academy of Sciences, October 25th, from which we take the following conclusions:

"Odorous substances, fixed or volatile, do not pass by the urine in confirmed cases of Bright's disease, so long as the coloring matters are eliminated. Since 1849 I have continued my experiments with the juice of a-paragus, or with the essence of turpentine. I have repeated them, without interruption, on a great number of subjects, at different stages of albuminuria, in the service of Prof. Rostan, during my residence as *interne* in Hotel Dieu, in 1854, '55, and '56. In the convulsions of children, as in those of pregnant and lying-in women; in scarlatina complicated with anasarca; in diseases of the brain; in neuroses; in paraplegia with lesion of the genito-urinary organs; in organic affections of the heart, liver, lungs, kidneys; in purpura, scurvy, diabetes, phlegmiasis, diseases of the skin; in the principal cachexie, and cholera, I have easily determined, by the aid of this particular sign, if albuminuria was connected with the existence of lesions belonging to Bright's disease. Indeed, I repeat the fact that the suppression of the function of eliminating odors does not take place, except in this affection exclusively. It is constant, absolute, incurable. The following example demonstrates this:

"In a man attacked with Bright's disease, whom I treated for five years, I never saw the passage of odors reappear in the urine, in spite of the general dropsy and the notable diminution of the albumen, and the real amendment of the constitution.

"*Deductions.*—Albuminuria may, then, in these cases, cease for a longer or shorter time, but the passage of odors is never re-established—a capital fact, which demonstrates the persistence of the lesions, and the impossibility of the radical cure of Bright's disease. The autopsies made at Hotel-Dieu sustain us in stating that this functional trouble coincides almost always with anatomical lesions of the second stage of Bright's disease. In a pathological view, the suppression of this curious function, observed exclusively in Bright's disease, proves the speciality of this affection, and the morbid changes which are peculiar to it. In a physiological view, this abolition of elimination of odors confirms the importance and the nature of the *rôle* of the cortical substance, in the secretion and elaborating of the urine. In regard to prognosis and therapeutics, this particular sign reveals at once the gravity and fatal incurability of the confirmed disease.

"*Conclusions.*—With these premises, I lay down the three following

propositions: 1st. The deficiency in the elimination of odorous substances by the urine is an exclusive sign pathognomonic of Bright's disease. 2d. This new sign, well ascertained, confirms, at the first view, the value of the symptom, albuminuria, the degree and the nature of the corresponding anatomical lesion. 3d. In default of albuminuria, a capital symptom, or of characteristic dropsy, the absolute suppression, incurable from the passage of odors in the urine, imposes on us at once the diagnosis, prognosis and treatment.—*Cincinnati Lancet and Observer*.

On the Suspension of the Radial Pulse in Forced Extension of the Arm.

By Dr. A VERNEUIL.

The suspension of the radial pulse is always observed when the extension of the forearm on the arm is actively or passively exaggerated. The difficulty experienced in exploring the ulnar artery does not allow an explicit statement in regard to the suspension of its pulsation. The anatomical dispositions harmonize with direct experience, so as to prove that in forced extension the arteries of the forearm and hand receive but little blood. In this position the aponeurotic expansion of the biceps and the brachialis anticus press the humeral artery against the convex projection formed by the coronoid process of the ulna; the artery is thus flattened for a length of about two centimetres, and, according to the experiments of M. Verneuil, this phenomenon must take place in a great number of physiological movements, particularly in mechanics—a fact which may serve to explain the predisposition shown by the termination of the brachial artery to the spontaneous arteriectasis. This fact could also be made use of as a means of arresting the flow of blood in cases of arterial hemorrhage from wounds of the forearm, when there is no assistant present to compress the humeral artery.—*Journal de Physiologie*—*Archives Générales*—*N. A. Med. Chir. Rev.*

On the Treatment of Inflammation by Digital Compression. By M.

VANZETTI, Professor of Clinical Surgery in the University of Padua, (Giornale Veneto di Scienze Mediche.)

From the success which has attended the treatment of aneurisms by manual compression of the arterial trunk, M. Vanzetti was induced to apply the same method to the treatment of the inflammation, in those cases where the artery leading to an inflamed limb is accessible to the finger. He has several times had recourse to digital compression of the femoral, brachial or subclavian artery in cases of phlegmon, arthritis, and inflammation of the fingers, and he has obtained such decided effects by

this treatment, that he has adopted it in all cases where it could be practised. Although this method is of course only applicable in certain cases, yet it is found that compression will not only quickly cure incipient inflammations, but even when the inflammatory process has made some progress, it may be arrested by a patient and preserving use of the same means. This plan of digital compression had been already proposed theoretically by some authors, but it was never employed by any of them, and it had fallen into oblivion. They have also proposed the use of instruments for the purpose of compressing the artery, without at the same time interrupting the venous circulation, but M. Vanzetti recommends that manual compression should alone be used, as being preferable to all others. Although this method of compression presents some difficulties in its performance, it is only because one or two persons are sometimes required to apply it exactly; the surgeon ought, in urgent cases, to make compression himself for two or three hours; this period will sometimes be sufficient to diminish sensibly the acuteness of the inflammation, and thus to save a seriously diseased limb. Most frequently the patient can himself perform the compression of the femoral, or the humeral, or even of the subclavian artery in cases of very considerable swelling of the arm; he will be able very easily to continue the compression for eight or ten minutes, and then to leave off and recommence after he has rested. These short intervals present no obstacle to the desired effect.

M. Vanzetti records two cases treated by digital compression in the hospital at Padua. The first was a severe case of phlegmonous erysipelas of the left arm, and the second was one of acute arthritis of the right wrist. In the first case the limb was enormously swollen, and a thread was placed around it to measure any change in its dimensions: digital compression was exercised on the subclavian artery for fifteen continuous hours, after which, there was decided relief of the disease and diminution of the swelling, and although there was subsequently extensive suppuration, yet the patient recovered completely. M. Vanzetti thinks that suppuration might have been prevented if the patient had come earlier under treatment, as he was advised to do, the second case was one of arthritis, and was treated by compression of the brachial artery, which was performed sometimes by the pupils of the hospital, and sometimes by convalescent patients, properly instructed. The pain and swelling of the joint were distinctly relieved, and the patient entirely recovered without the adoption of any other treatment whatever. In this case the patient was able to distinguish whether the compression was properly or improperly practiced by the amount of relief which he experienced.

The late Dr. Marshall Hall's Proposition for a New Operation of Lithotomy.

TO THE EDITOR OF THE LANCET—SIR—In the "foreign department" of your valuable journal I noticed a proposition made by M. Valette of Lyons, for a new operation for the removal of vesical calculi, which he called the hypogastric operation; and he narrated several cases in which it had been successfully performed by him. Whatever may be the ultimate influence of this proposition of M. Valette on the present practice, I feel that an interest is attached to the subject from the fact that my friend the late Dr. Marshall Hall held, in the month of June 1855, as nearly as may be the same views as those lately advanced by M. Valette. A copy of the lettre cachetée, which Dr. Hall told me had been deposited in the institute of France, has been kindly procured for me by Mrs. M. Hall from M. Flourens of Paris, and I enclose it to you. I feel sure you will agree with me, that the document is of sufficient interest to be published in your journal.

I am, sir, your obt' serv't,

FREDERICK WILDBORE, F. R. C. S.

Brighton, Dec. 1858.

Ulcers of the Legs, not of a Syphilitic Character; Exhibition of Potassium; Cure without the Assistance of Rest.—Every method of treatment directed against diseases frequently observed in the laboring classes, and which does not compel them to interrupt their daily occupations, deserves favorable notice. Thus Baynton and Ph. Boyer rendered a great public service in discovering and propagating the treatment of ulcers of the legs by the application of straps of adhesive plaster. This very year we saw the late Ph. Boyer, but a few months before his death, apply this method which Roux imported from England in 1814. He began by cauterizing deeply the sore with lunar caustic, and then with straps of plaster about an inch in breadth, and six or eight inches longer than the circumference of the limb, he covered the ulcer with a series of imbricated rings, the uppermost of which reached about an inch above the sore, and the lowest strap as far below. A roller or an elastic stocking was afterwards applied to the leg and foot, and was preserved night and day. The apparatus was removed after forty-eight hours and subsequently at irregular intervals whenever the patient complained of pain. Since the year 1832, when Ph. Boyer proposed to the *Conseil général des Hôpitaux* the adoption of this method, and also that individuals, bearing ulcers of the legs, should in future be treated only as out-door patients, the duration of the treatment has been on the average

26 days. In the wards of Professor Roux and Velpeau, where this method was adopted, and moreover the patients kept constantly in bed, 15 days was the mean average of the same treatment. It is, however, a fact proved by observation, that the cicatrix in the first instance is stronger, more supple, and resists better than the scar formed while the patient was confined to his bed. Boyer's treatment leaves therefore few chances of relapse, and further, the invalids are permitted to walk, a two-fold advantage which cannot be too highly appreciated in the case of indigent persons.

However, if Baynton's method is in many instances productive of beneficial results, it occasionally fails even in cases which are under no specific influence: it is therefore useful that the surgeon should have at his disposal some other means possessed of the same advantages, and, according to two respectable practitioners of the City of Nantes, Drs. Tigé and Trastour, iodide of potassium supplies the required desideratum.

In a recently published paper, Mr. E. Trastour states, that for the last ten years Dr. Tigé has been in the constant habit of exhibiting iodide of potassium for the treatment of the ulcers of the legs, without once having failed in obtaining a cure. The author estimates at upwards of 20 the number of patients who have recovered in spite of the most adverse circumstances. The following is a specimen of the cases recorded in Mr. Trastour's publication:

A husbandman, aged 55, was affected for ten years with an ulcer situated on the internal surface of the lower half of the left leg; the sore was broad, its fundus was of a purple hue, its depth 5 lines, the secretion sanious and reddish; the skin around it was tumefied, and covered a vascular network of varicose veins which extended as far as the foot. On April 26th, Mr. Tigé prescribed from half to three-fourths of a drachm of iodide of potassium daily, fomentations with the decoction of wall-nut tree leaves, and pressure with a linen roller. On May 8th, the ulcer was almost healed, but the skin being still tight, red and shining from the foot to the middle of the leg, the treatment was persevered in with the addition of linseed-meal poultices. On May 29th, the wound was entirely cicatrized, and the patient, who during the whole time of the medication had not interrupted his agricultural labors, walked eight miles, without the least pain, for the purpose of exhibiting his leg.

Mr. Trastour relates seven or eight equally satisfactory cases which occurred in his own practice. He further remarks, that the method towards which he calls the attention of the professors prevents in no wise the application of topical remedies, which alone in numerous cases

are sufficient to insure success; but the facility, speed and solidity of the cure due to iodide of potassium, united with external applications, in cases in which the latter would have been inefficient, seem to him unquestionable.

The doses in which Messrs. Tigé and Trastour exhibit the drug, are from $\frac{1}{2}$ a dr. to 1 drachm daily; in severe cases, Mr. Trastour has given as much as $1\frac{1}{2}$ dr., a quantity he has never exceeded. He prescribes it in water, a tablespoonful to every $\frac{1}{4}$ of a drachm before meals. When the medicine is prescribed in large quantities, 2 ounces for instance at a time, the apothecaries at Nantes have consented to sell it at the low price of two pence a drachm to poor persons. On the average, the cost of the treatment is from one penny to three-pence daily during a month or two, a very moderate expenditure, when it is further considered that the patient, not being retarded by inaction, is enabled to earn his livelihood.—*Journal of Practical Medicine and Surgery.*

Of the Treatment of Organic Strictures of the Urethra by Iodide of Potassium.—Dr. Thielmann, surgeon of one of the hospitals of St. Petersburg, has utterly relinquished the last thirteen years the use of the mechanical means habitually employed for organic strictures of the urethra, which he treats exclusively by iodide of potassium. This medication has perfectly succeeded in 27 cases of stricture presenting a great diversity with respect to seat, extent, structure, etc. With the greater part of the patients a more or less copious gonorrhoeal discharge was present at the same time. The oldest strictures were of two years' standing, the most recent of eight months. With a great number of subjects, bougies Nos. 2, 3 and 4 could be introduced without much difficulty; with two individuals a bougie No. 1 could not penetrate in consequence of the tortuous direction of the passage. The stricture had already induced a dilatation of the membranous portion of the urethra situated behind the obstacle. The seat of the strictures treated by Dr. Thielmann, was sometimes the spongy portion of the urethra in the vicinity of the bulbous portion; at other times this latter portion itself. They occupied in three cases the membranous portion; in none the fossa navicularis. On exploration, when such was possible, the strictures generally presented themselves in an annular or semi-annular form. In some patients they seemed to be composed of irregular scars, of variable shape, which could be felt by the surgeon touching externally the course of the urethra. They had all, without exception, a callous consistency.

Mr. Thielmann exhibited to each of his patients three tablespoonfuls a day of the following solutum:

R—Potassi Iodidi..... 2 dr.
 Aq. destill..... 5½ oz.

He prescribed a rigid milk diet, permitting amylaceous food. When any iodine symptom manifested itself, he diminished the dose until the patient could bear a stronger one. Iodide of potassium regularly produced the effect of determining a gonorrhœal discharge, if it did not previously exist, or of increasing it, if it was already present. As the discharge took place, a softening, a melting, as it were, was effected in the nodular tissue, which constituted the stricture, and the stream of urine returned by degrees to its normal dimensions. The duration of the treatment varied from a fortnight to two months, according to the degree of the coarctation. It was sometimes requisite momentarily to suspend the use of the iodide of potassium, in order to avoid the accidents that might be superinduced by its protracted use. When the nodular tissue of the strictures was felt externally, Mr. Thielmann ordered, in addition to the external use of the iodide of potassium, frictions along the part of the penis corresponding to the urethra with an ointment composed of

R—Potassæ iodid..... 1 dr.
 Adipis..... 1 oz.

The gonorrhœal discharge for the most part ceased spontaneously. When it was persistent it was treated by the ordinary means.—*Med. Zeitung Russlands—Journ. Pract. Med. and Surg.*

On Hospital Gangrene. By M. MAUPIŃ. (*Mémoires de Médecine Militaire*, tome xx., p. 368.—This paper is the result of M. Maupin's observations upon hospital gangrene as it appeared in the French army of the East, in which it committed frightful ravages. In reference to the conditions under which it may become developed, M. Maupin observes that overcrowding of patients has usually been considered a necessary condition of the production of the disease; but that at the hospital into which the Russian embassy was converted at Pera, and which united every condition of salubrity—and among these ample space—gangrene broke out amongst the wounded officers seven days after the arrival of eight others severely wounded, the wounds of the preceding occupants having been slight. Still, the gravity of the disease will generally be found to be proportionate to the amount of vitiation the air has undergone. The disease may indeed arise even in the open air when there is a considerable agglomeration of wounded soldiers, examples of which occurred to the author in Algeria. Overcrowding may be only relative, and a given number of patients that in

the time of peace may be advantageously treated in a hospital, will in the period of war give rise to hospital gangrene. Not only do the numbers of the patients, but the gravity of the cases and the constant succession of such cases, increase the hygienic exigencies. The rule is, that the wounded soldier requires space and air in proportion to the gravity of his wound; and when hospital gangrene is once set up in a ward, the dispersion of the subjects of it is a measure alike beneficial to themselves and the other patients. As long as the medium remains unchanged, the treatment is but tentative, and the results are uncertain.

In order properly to appreciate the instability of the results of treatment, we should bear in mind that, if epidemic hospital gangrene may be an essentially local affection, it is frequently during a campaign, but the expression of a general modification of the economy, of a true intoxication, the energy of which, intimately dependent upon the salubrity of the locality, and the number and nature of the wounds treated therein, is increased or diminished, revived or extinguished, with the increase or diminution of the number of the patients, with their agglomeration or dispersion. Means which in isolated cases of gangrene may act heroically—as the actual cautery, sulphuric acid, perchloride of iron, and in milder cases, citric acid, carbon, iodine, etc., are in the epidemic form either powerless or only of temporary benefit. It is this which explains the differences of opinion that prevail treatment of this disease.

In respect to the local affection considered separately, we must recognize an acute and a chronic form, a distinction of importance as regards treatment. The acute form is denoted by the conversion of the tissues into a pulposus or putrilaginous magma, and which, as soon as the destructive process is arrested, becomes detached through a series of eliminatory processes. The ulcerative is the chronic form of the disease. The putrilaginous form is almost always primary, and is found almost exclusively in recent wounds; while the pulposus form, though often also primary, is also often met with in old wounds, and it does not pursue the same rapid and destructive course as the putrilaginous form. The ulcerative form is almost always consecutive to the two other forms, appearing especially in the case of old wounds, or after amputations these have necessitated. In the putrilaginous and pulposus forms the most appropriate measures are those which hasten the separation of the parts affected, and stimulate the reparative process. Of these, the actual cautery, sulphuric acid, and the perchloride of iron occupy the first rank. In an hospital in which there are at least 300 cases of hospital gangrene at the same time, the application of the actual cautery is made with difficulty, while, although it is just as painful as the other

means, it does not adapt itself so readily to all the situations, forms, and depths. The sulphuric acid has been found by the author preferable to it and to the nitric acid, while other practitioners give the preference to the perchloride of iron. The eschars once separated, styrax and aromatic wine proved the best of topical applications; while, when cicatrization was delayed, or there was a tendency to substitute ulcerative form, citric acid, camphor, cinchona and carbon, tincture of iodine or nitrate of silver, and if necessary, nitric acid, imparted a new and favorable impulse to the cicatricial process. The formation of a crust or magna on the surface of the sore by means of some of the above powders has been found to encourage the healing process, and to diminish the patient's sufferings. For the chronic form the perchloride of iron is better adapted than the sulphuric acid. But let the local measures employed be what they will, success will be impossible or transient, unless the general conditions and the necessity of removing the patient from the infected medium be borne in mind.—*Br. & For. Chair. Rev.*

Tears containing Sugar.—Dr. Gibb showed to the Pathological Society some tears shed by a young married lady, aged 21, the mother of one child, who has had diabetes for two years since the child was weaned. They contained a large amount of sugar as contrasted with that in an equal bulk of her urine, which was of the specific gravity of 1043. An evaporated drop of the tears on a piece of glass gave a much thicker and more opaque crust than was yielded by a drop of the urine.—*Medical Times and Gazette*, July 3, 1858.

The Medical Chronicle.

LICET OMNIBUS, LICET NOBIS, DIGNITATEM ARTIS MEDICÆ TUERI

MOTIVES TO STUDY.—Of the ostensible motives to acquire the medical profession, it is to be lamented that many are of a most unworthy kind. The parent, who numbers in his family circle many members, may, in his anxious concern for the future prosperity in life of each, feel an inward temptation to decide without reference to the inclination or choice of any. In possession of domestic rule, he fixes his determinations, and proceeds to give them, when the suitable time arrives, their proper effect. Without realizing whether there be in his child an adaptability or not to the end in view, he summarily measures his course. He takes a worldly-wise view of the transaction, and does that which, he believes, will bring most elevation to his relatives or the largest riches to

his offspring. Unaided by any other influence, the issue must be a miserable failure. No young man will acquit himself creditably in any calling into which he has not engaged "con amore." Unless he has a preference himself, no father's constraint, nor mother's persuasion, will deprive his studies of a toilsome character. Learning to an extent may be acquired against his will, but, shallow or indifferent as at best it must be, it will make no lasting impression on his memory. In after years should circumstances,—doubtful though the opportunity must be—present him with the occasion of entering upon practice, he finds no satisfaction in its engagements nor pleasure in his duties. He retires from the contest disturbed and discontented; experiencing, with deep bitterness, the overwhelming conviction, that he is in a pursuit for which he was never fitted.

Again, it is no effort of the imagination to say there may be those who, having entered the threshold of medicine, governed by different reasons, continue with perseverance therein and feel no other excitant to their attendance upon lectures or closet studies than the solitary ambition of a successful examination. This dreaded ordeal has early begun to seize their apprehensions, its tests are magnified because the creations of fancy are uncorrected by a final attestation, and it soon gains the entire exertions of the mental abilities in its behalf. It is not to be denied that such an object is laudable,—but as, with the motive in the antecedent instance, it is praiseworthy only to a certain extent, like it, approval can only be extended by knowing the propriety of concomitant conditions and, here as there, the error is one of engrossment. To one in such a case, we say he may, he probably will succeed. His aim will be attained as far as appearances go, but there will be no soundness nor sterlingness in him. His impelling motive has called forth learning, for the most part, of minute details and descriptive lessons which he will find have, unaided, made him only scientific;—the acquisition was a work of necessity, and the burdens it has reaped will, moreover, unless preserved by force, separate spontaneously; in after life, the only incitement to knowledge will be removed, and further progress may most likely be unsought, uncared for, and untried; while retrocession into the dark mists of uncertainty or the unenviable regions of ignorance will, naturally, be facile in the extreme. No student who is thus actuated will be deeply read. His books are found to be few and the most popular of the common class called manuals, their leading claim to purchase is concentration—they are compact, brief, and to his purpose. A single one upon each department suffices, serving as the embodiment of an entire medical library. But all the researches and reflections of the great

minds of the profession, who are not compilers of such a style of literature, are unknown. Aware that the great test, which is ever rising its phantom proportions before him, is not of a demonstrative character, and that he is not required to evidence the possession of any practical knowledge, he rests contented with getting up first principles and becoming grounded in the refined abstrusities of specialities. But failure is certain—though it be not near: the great superstructure has not been built, and to him practice, when it comes, will turn out a matter of routine—he will be in the dark dealing heavily, with murderous weapons, incessant blows on all who approach him.

There is another class of motives at least as powerful and as prevalent as those now depicted, but they are not so destructive in their tendencies. They rest upon a principle of self-advancement, and can only prove to be influential when favored by more or less personal skill and compatible extraneous circumstances. A man, for instance, seeks to acquire a lofty reputation or an honorable position of distinction among his fellows, and in the eager struggle he puts forth the most strenuous exertions at his disposal to be successful. Yet conduct such as that implies diligence in study, continuance in well doing; it has talent at its command and is accumulating daily a fuller shew of acquirements. These elements in his progress necessarily make him clever, and give him insuperable advantages over the pressed-man or the groveller with whom he is now compared. In his treatment of the sick, far greater success must follow; he can give a reason for what he is doing, and does the best for his patient which the present resources of medicine will permit. Estimable, however, as such advantages are, the motive is positively as bad as with the former, for it is a sordid one, self only is at the bottom, and, if it were not for the complacency and congratulations he experiences and awards himself, he would not have been a laborer in the world's infirmary wherein he officiates. To his eye, his patients suggest no other consideration than what they will yield,—he views them as interesting cases, or delightful commentaries upon the work of pathological deterioration, or striking illustrations of the capacities of the human frame for physical sufferings,—his affability towards them is measured strictly by their activity in increasing the boundaries of his fold or attracting to him other customers with themselves. And, if he be also of a covetous turn of mind, then his value of the sick and dying, to whom he ministers, is accurately adjudged by the weight in current coin for which they will be good. Surely feelings and actions such as these are not right. The world may have been gained, but the counterbalancing loss before the individual is immeasurably greater.

There are sundry other instances of improper motives which might perhaps be profitably ventilated, but these humiliating examples must now suffice. We have no hesitation in affirming that there is only one motive which can be called worthy or acceptable—but one which will bear the examination of a pure and true and just and good mind—none other that will find a resting place in a great, manly, frank, and philanthropic heart,—it alone that will never fail, which, when all else is forgotten as the baseless fabric of a vision, will still flourish in perpetuity “amid the wreck of matter and the crash of worlds.” It is, simply, charity. Charity in its most comprehensive signification—and there is none too ample.

“Whether we name thee Charity or love
Chief grace below, and all in all above—”
“True Charity a plant divinely nursed
Fed by the love from which it rose at first.”
“Exuberant is the shadow it supplies
Its fruit on earth, its growth above the skies.”

Pope has also well said,

“All must be false that thwart this one great end,”—Charity.

In starting upon the work of medicine, in commencing his labors, it is not to be expected that this powerful influence should be a personal impulse of the student's own;—in short, that he has independently made a deliberate choice in favor of this unsurpassable virtue. The rule rather appears to be that the profession is entered upon from other considerations such as the advice of friends,—an intuitive preference,—the best account to which one can be turned,—the desire to have a means of livelihood everywhere available—and so forth: while with a lesser number no conclusive reason can be assigned, they may find themselves so engaged without knowing why or because it is vaguely said to be “about as good a thing as any other.” Dark, blind resolves and executions, such as these, by man, are not uncommon in his affairs. As intelligence however increases, as events begin to be understood in their actual causes, premises are placed before the will, it is invited to make its election, the question then to be solved is, shall the reason be fostered as it was, or shall it be brought into accord with the dictate of the newly acquired information. And it is a matter of hearty congratulation to know that many who begin in error, sooner or later end in truth. Leaving the unworthy motives which, through ignorance, they entertained at their commencement, they have, as they have progressed in discretion, rejoiced in experiencing true Charity as their real motive to perseverance.

QUARTERLY REPORT OF THE MONTREAL GENERAL HOSPITAL.

Ending 27th January, 1859.

Patients remaining from last quarter,.. 64	Died during the quarter,..... 12
“ admitted present quarter, ....175	Now in Hospital,..... 81
	Discharge during quarter, ...146
239	239

IN-DOOR PATIENTS.

Males,..... 102
Females,..... 73
175

OUT-DOOR PATIENTS.

Males,..... 550
Females,..... 638
1188

DISEASES AND ACCIDENTS.

DISEASES, &c.	Admitted.	Died.	DISEASES, &c.	Admitted.	Died.	DISEASES, &c.	Admitted.	Died.
Abortio,.....	1		Epilepsia,.....	3	1	Orchitis,.....	1	
Abscessus,.....	1		Erysipelas,.....	8	1	Ostitis,.....	1	
Adontis,.....	2		Febris Com. Cont.,.....	3		Paralysis,.....	2	
Ambustio,.....	5		Fistula in Ano,.....	1	1	Periostitis,.....	2	
Amenorrhœa,.....	1		Fractura Comp. Co.,.....	1		Phthisis,.....	4	
Anasarca,.....	2		“ Simplex,.....	6		Pneumonia,.....	4	1
Atrophia Cerebri,.....	1		Gastrodynia,.....	1		Psora,.....	1	
Bronchitis,.....	17		Gelatio,.....	2		Purpura,.....	3	
Bursitis,.....	1		Glossitis,.....	1		Pyæmia,.....	1	1
Cancer Epithel,.....	1		Gonorrhœa,.....	1		Rheumatismus Acut,.....	5	
Catarhus,.....	5		Hydrocele,.....	1		“ Chronic,.....	18	
Chlorosis,.....	1		Hydropneumothorax,.....	1		Scarlatina,.....	1	
Cirrhosis,.....	1	1	Hydrosarcocœle,.....	1		Staphyloma,.....	1	
Conjunctivitis,.....	2		Hydrothorax,.....	1	1	Stillicidium Urinæ,.....	1	
Contusio,.....	5		Hysteria,.....	1		Stricture Urethræ,.....	1	
Cynanche Pharygea,.....	4		Inebrietas,.....	1		Subluxatio,.....	2	
Cystitis,.....	1		Iritis,.....	1		Synovitis,.....	1	
Cystorrhœa,.....	1		Mania,.....	0	1	Syphilis,.....	9	
Del. Tremens,.....	4	1	Morbus Brightii,.....	0	1	Sonillitis,.....	3	
Diarrhœa,.....	1		“ Cordis,.....	2	1	Tumor (fibro-nuclea		
Dysenteria,.....	7		“ Coxæ,.....	1		[ted,.....	1	1
Dyspepsia,.....	3		Necrosis,.....	1		Ulcers,.....	5	
Emphysema,.....	1		Nephritis,.....	1		Vaccinia,.....	1	
Endocarditis,.....	1		Neuroma,.....	1		Varix,.....	1	
Encuresis,.....	1		Edema,.....	1		Vulnus,.....	1	

OPERATIONS, &c., DURING THE QUARTER.

Major Operations.—Amputation of leg, 1; of foot (Hey's) 1: Excision of fibro-nucleated tumor, 1: Staphyloma removed, 1: Hydroceles tapped, 4; tapped and injected, 1: Synovial bursæ tapped and injected, 2: Tenotomy, 1: Sequestrum removed from tibia, 1. Total, 13.

Minor Operations.—Starched bandages applied, 13: Venesections, 5: Cuppings, 34: Leeches applied, 24: Ulcers strapped, 183: Wounds dressed, 17: Teeth extracted, 137: Abscesses opened and other incisions, 128. Total, 541.

Fractures treated.—In-door, 7; outdoor, 2: total, 9.

ATTENDING PHYSICIANS—DRS. HOWARD AND JONES.

ROBERT CRAIK, M.D.,
House Physician and Surgeon.

MEDICAL NEWS.

During the year 1858, 1205 cases of fracture were treated in the London Hospital.—Mr. Robert Chambers repudiates the authorship of "Vestiges of the Creation," ascribed to him in the catalogue of the British Museum.—The number of persons now known to have been poisoned by eating the lozenges with which arsenic was mixed at Bradford is 225, of whom eighteen have died. Five or six others are still suffering from the effects of the poison, and the recovery of two of them is doubtful. 136 of the poisoned were adults.—A tribe of aboriginies has been found in Australia presenting the remarkable peculiarity of being entirely without hair, neither males nor females having hair on their bodies at any period of life.—In the ascent of people called Nah-pih-shen near Manilla, parturient women are placed into a tub, into which water is poured, with the design of facilitating the accouchement.—There are five thousand practising dentists in the United States, who consume over two millions and a half of dollars in gold foil and plate.—Two gentlemen of Baltimore have recently taken out a patent for converting a mixture of pearl-ash, powdered sal ammoniac, lobelia, oil of anise and caraway, alcohol, grass, rape, rum, cascarrilla bark, opium, sumac, and stems or refuse of Tobacco, into sheets for wrapping woollen goods to prevent moth's from eating them, lining for cases of the same, and wrappers for cigars or tobacco.—Dr. R. B. Symmans of Brooklyn has been appointed by the Board of Foreign Missions of the Reformed Dutch Church, a Missionary to Japan. Dr. S. Leaves a growing and remunerative practice in Brooklyn.—Chloroform has been administered *thirty thousand times* in the hospitals of London during the last ten years, for the performance of surgical operations.—A London car-doctor, who promised to "cure deafness in ten minutes" has been obliged to refund his fee, and committed to prison. The microscopists of Germany have entered into an arrangement by which once a year microscopical specimens takes place. At the last meeting, twenty-four microscopists were present, and 3000 preparations offered in exchange.—Some of the European journals are making merry over the fact that a woman has sent to the Academy de Medicine a *suspensorium scroti!* The inventoress submits it to the approval of the Medical faculty, assuring them that it is a master-piece. The suspensorium was sent back to this new expioress of terræ inroguitæ mulieribus.—The London Medical Times and Gazette for December last says, "Honours are falling thick on Sir Benjamin Brodie. Last week elected President of the Medical Council, this week President of the Royal Society, he stands in a higher position than any surgeon has ever attained before in this country."—"In my girlhood," said a lady to Roger's the poet, "I had a very severe illness, during which I heard Dr. Turston declare to my mother in the next room, that I could not live. I immediately called out, 'but I will live Dr. Turton?' and here I am now sixty years old.