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Society Proceedings.

THE MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, December 23rd, 1892.

JAMES STEWART, M.D., PRESIDENT, IN THE CHAIR.

A Second Series of Cases of Transplantation of Skin after Thiersch's Method.—DR. BELL read a paper on this subject, and exhibited several cases to illustrate his remarks.

DISCUSSION.

DR. D. J. EVANS spoke of several cases he had observed in Prof. Thiersch's Clinic at Leipsic, and the treatment was always successful.

DR. FOLEY suggested that this method of skin grafting might be used with advantage in treating leucoderma and tattoo marks, by removing the affected skin and supplying new skin.

DR. SMITH asked how deep the skin had to be cut and if hair grew on the new skin.

THE PRESIDENT.—If tactile sensation was present.

DR. BELL, in reply, said that the skin is removed down to the true skin, not into it, for the fibrous tissue will interfere with union. The

hair follicles are thus not taken, and often the only means of distinguishing the transplanted skin from the normal is by the absence of hair. The sensation is as good as in healthy skin.

Carcinoma of the Peritoneum.—DR. ADAMI exhibited specimens from a case of carcinoma affecting the peritoneum. The patient, a Polish Jew, aged 25, was attacked by sharp epigastric pains about August, 1892. These were unremitting and were increased by ingestion of food. The abdomen was noticed to be enlarging in the first week of October, and the patient entered the General Hospital upon October 22nd, under Dr. Stewart. Upon entry the whole lower half of the abdomen was very painful, so much so that the patient was frequently forced to cry out. After admission, the abdomen rapidly increased in size, and the patient showed increasing emaciation of the rest of the body. There was constipation but no vomiting. The patient was tapped upon October 25th, and 120 oz. of a milky, turbid fluid were removed. The fluid was rapidly replaced, so that between this time and the death of the patient, upon December 12, the operation was repeated five times, from 115 to 170 oz. of fluid of the same milky nature being removed at each tapping. Nodular growths could be felt, after tapping, running in various directions; a prominent band ran across the abdomen about one-half inch above the umbilicus, and in the left iliac fossa a great aggregation of nodules

could be distinguished. The post-mortem was performed by Dr. Martin, who forwarded the matted intestines *en bloc* to the Pathological Laboratory. The prominent band referred to above was evidently the thickened and much contracted great omentum, infiltrated with cancerous growths. The mesenteries also were greatly thickened and contracted. Numerous lenticular translucent growths, from 0.5 cm. upwards in diameter, were scattered over the peritoneal surface of both large and small intestines. These latter were matted together by soft recent inflammatory lymph. Apart from the infiltrated mesenteries and omentum which were fairly firm, the soft almost gelatinous growth upon the intestinal wall was most marked around the splenic flexure of the colon and again at the beginning of the sigmoid flexure. At the splenic flexure all the walls of the viscus were involved, and there was marked stenosis. Here probably was the origin of the carcinoma. The mucous membrane of the sigmoid flexure and of the rectum was unaffected.

Upon stripping off the muscular coats of the intestines, the lymphatic plexus was found to be injected with fatty matter and the main lymph trunks could thus easily be traced to cheesy glands lying completely involved in the mesenteric new growth. A portion of this naturally injected submucosa was exhibited. Previously Dr. Adami had examined the milky-looking ascitic fluid, and had found it to be almost wholly deficient in fat, though containing a large amount of proteid, noticeably of globulin.

It would seem, therefore, that in the condition of the lymphatic system is to be found an explanation of the pseudo chylous ascites here described—a form of ascites that not unfrequently has been noted in connection with carcinoma of the peritoneum. The mesenteric lymphatic glands become surrounded by new growth, the vessels passing off from them become occluded, hence from the distended lymphatics of the intestinal wall there occurs extravasation of the fluid of the lymph, the fatty globules, as shown in this case, being left behind, and forming an inspissated mass injecting the lymphatics. Did any of the distended lymphatics undergo rupture, then a condition of true chylous ascites would be induced, such as has been found by Reichenbach in a case of lymphadenoid disease affecting the mesenteric glands.

Microscopic examination of various regions proved that the new growth, although resembling colloid cancer in general appearance, was not of this nature—the alveoli were greatly distended and filled with mucoid rather than colloid material. In some the cells could still be seen, in others the cellular elements had almost wholly degenerated and given place to mucoid

material. This form is by some spoken of as carcinoma myxomatodes; but inasmuch as that term is applied more frequently to cases where stroma and not the alveolar contents undergo mucoid change, it is better to describe it as a myxo-carcinoma.

Cyst of the Right Ventricle.—DR. ADAMI exhibited a brain presenting this condition. At the autopsy the dura mater was found to be generally thicker than normal, and adherent to both calvarium and pia mater. Upon removal of the brain, a cyst was ruptured, and from this poured a clear, colorless fluid. The cyst was nearly two inches across in its largest diameter (the antero-posterior); and about one and a half inches in breadth, extending from under the angular gyrus and second occipital convolution forwards to a point one-half inch behind the ascending parietal convolution in the mid-parietal region.

DR. ADAMI pointed out the facts that militated against this being considered a cyst formed by the breaking down of a glioma; that it was not a hydatid cyst, and that the appearance of the walls was strongly against its being an embryonic cyst. There was left the possibility of its being the sequel of an old hæmorrhage—yet the absence of any signs of pigmentation of the walls was against this supposition. It would be necessary to harden the brain and examine microscopically before any sure statement could be made.

DR. STEWART said that the patient was a man aged 40, and who had suffered for the greater part of his life from headaches, which came on every week or every two weeks. Three weeks before death he was seized with a much more severe headache than usual; he began to lose control over his movements; he noticed that he stumbled against various objects; vomiting came on, and he became soporose, from which he passed into deep coma and death. There was no disturbance of vision, and the eyes, on examination, proved to be normal; there were no localizing symptoms.

Hernia of an Ovary through the Inguinal Canal, in an Infant.—DR. JAMES BELL related the case of a female child, twelve months old, upon whom he had been called to operate for inguinal hernia which had appeared during the course of whooping cough. Frequent attempts to reduce it had failed; it was hard, and seemed like omentum. On cutting down, the sac was found closely covering the tumor, and on removing the sac the hernia was found to be covered with peritoneum. On manipulation there was an obscurely hollow feeling. He (Dr. Bell) thought that it might be a volvulus, and ligatured the pedicle and cut it off. After removal he was no wiser than before as to what the structure was, unless it was an ovary.

DR. ADAMI said that he had examined the

specimen, and found that it was the ovary and fallopian tube of a young child. Towards the pedicle there were found undoubted tubercles. Here was an ovary in a false position, and its weakened condition rendered it an easy prey, and Dr. Bell had done well to remove the tubercular focus.

DR. SMITH said that this was the second time he had seen this condition. Seventeen years ago he saw Mr. Golding Bird remove an ovary from the inguinal canal.

A Case of Poisoning by Chlorate of Potassium.—DR. WYATT JOHNSTON gave the following history:—

The patient, a boy aged 10, on December 14th on getting up in the morning had a sore throat and did not feel well. He went to work, but during the day he felt so ill he returned home, and his mother, thinking that he had quincy, gave him a solution of chlorate of potassium to drink. The amount taken during the day was nearly two tumblersful of a saturated solution, equal to about six drachms of the salt. In the evening Dr. J. A. Macdonald was called, and found the boy in a dying condition, with intense cyanosis of the face and extremities. The autopsy was performed at the order of the Coroner. All the conditions indicated that death had been caused by the potass. chlorat. This salt destroys life by decomposing hæmaglobin into met-hæmaglobin. There were two ecchymotic spots, one on the inner surface of the left fore-arm and the other on the anterior surface of the right leg. On incision they were found to be due to extravasated blood of a dark coffee-brown color and sticky consistency, and which did not change color on exposure to air. The blood removed from the heart showed the characteristic appearances of met-hæmaglobin; it was thicker than normal, of a peculiar chocolate-brown color. The kidneys, spleen, lungs, bone marrow, and brain showed the characteristic brown coloration; urine contained a large amount of albumen but no blood or met-hæmaglobin. Spectroscopic examination of diluted blood gave deep absorption bands at C and F, in addition to two paler bands at D and E, which is characteristic of met-hæmaglobin.

The appearances might be mistaken for those found in acute infectious fevers, or poisoning by other substances which produce met-hæmaglobin, but here chemical analysis showed a large quantity of potass. chlorat.

DISCUSSION.

DR. BULLER thought that the susceptibility to the action of this drug was very great in some individuals. He had met with two persons, mother and son, who could not take it at all, five grains three times a day would make them quite ill.

DR. BELL asked if there is any hope of prolonging life when met-hæmaglobin has been formed—if there is any chance of it being eliminated?

DR. LAFLEUR wanted to know whether the salt was changed in the stomach, or whether it was absorbed unchanged, and circulated as such in the blood? He referred to a case he had reported—a case of poisoning by potass. bichromat.—where the symptoms and conditions found were the same as in this case. One marked feature was the intensity of the rigor mortis and the length of time it lasted, for in seventy-two hours it had not disappeared. The blood was in the same condition and the lungs contained an abnormal form of gas of some kind.

DR. FOLEY said that a dermatitis associated with this condition is very rare; only one case is recorded. Two cases of an erythematous rash have been reported.

DR. STEWART said that potass. chlorat. may cause death by rapidly inhibiting the action of the heart or by the rapid degeneration of the heart muscle, without affecting the blood in any way. DR. JOHNSTON, in reply, said that very little is definitely known of the changes in the blood. The production of met-hæmaglobin is involved in obscurity, and it is now considered to be a mixture of several compounds. He could not say what changes the salt undergoes in the stomach, but it appeared as such in the urine. As to treatment, bleeding and transfusion seem to be indicated, but he cannot find if this has been practised. It has been stated that if the blood is strongly alkaline the change takes two or three times as long to be accomplished, so he suggested making blood alkaline, but such treatment is not supported by any clinical evidence. Intense engorgement of the brain with the altered blood seems to be the most likely cause of the rapid death.

Stated Meeting, January 6th, 1893.

JAMES STEWART, M.D., PRESIDENT, IN THE CHAIR.

Simple Chronic Salpingitis.—DR. ADAMI exhibited two very typical specimens of this condition, which he owed to Dr. Alloway. There was no evidence of tuberculosis. Both showed marked atresia towards the uterine end of the tubes, with considerable dilatation above this, and fibroid thickening of the walls. The tubes contained sanious pus.

Papillary Cysts, Adenoma of the Ovary.—DR. ADAMI also exhibited a specimen of this condition sent to him by Dr. Alloway. There were extensive papillary growths into the cysts, which contained thin mucinous fluid.

Papillary Growths in the Lower Bowel.—DR. SMITH gave the following history: The patient, a tailor by occupation, under my care

for the last 10 or 12 years, complained of severe dysmenorrhœa necessitating leaving off her occupation several days monthly. She also suffered from mitral regurgitation. In addition to dysmenorrhœa she complained of a pain in her left side, which persisted throughout the intermenstrual period. At last I decided on abdominal section. This was done two years ago; she made a good recovery, and the case was reported at the time. The pain, however, has not been altogether cured. Dysmenorrhœa, of course, ceased, with the exception of the first period after the operation; she has had no period since. The pain in the side and back still persisted. Soon after the operation she began to complain of passing small quantities of blood per rectum, which, at the time, I supposed was a sort of vicarious menstruation, this hemorrhage generally occurring at the menstrual period. After a time, however, she brought me some small pieces of flesh about the size of a split pea, one or several of which she noticed herself passing each time she had a hemorrhage of bright red blood. I at first thought them little polypi or warts. On examining the rectum I could find no growth there. On making a vaginal examination, however, I thought I could discover some thickening of the left vault,—some indication of an irregular shaped mass in the left iliac region, which, owing to the extreme corpulency of the patient, was difficult to outline. Hemorrhage increased steadily; last time there was a teacupful of bright red blood. She brought me several of the pieces referred to above, which I handed to Dr. Adami for microscopic examination. It is important to ascertain whether these are parts of a simple or malignant growth.

DR. ADAMI described the small growths in question. He pointed out that they were evidently hypertrophic growths of the mucous membrane. From their structure he considered that they had developed in the lower portion of the colon, and this opinion gained support from the bright red, unaltered blood which passed out along with them. As to the question whether they were of malignant nature or not, he was inclined to consider them non-malignant; they contained comparatively few blood vessels—their glandular structure was typical, not atypical.

DR. ADAMI exhibited a specimen of ulcerative colitis from the museum of McGill College, presenting very similar papillary growths. He pointed out the frequent relationship between the production of such papillary adenomata and chronic inflammatory disturbance. The increased nutrition in the hyperæmic zone around old ulcers, for example, may originate such overgrowth of the mucous membrane in these positions. Other cases of these papillomatous growths are, however, accompanied by no definite history of chronic inflammation.

DR. SMITH expressed his satisfaction with Dr.

Adami's clear description of the condition present. His observations of the patient confirm Dr. Adami's remarks. She does not resemble a patient suffering from malignant disease. When her bowels are moved she suffers pain; and if the motion is hard, its passage is followed by bleeding and pieces of tissue. In one of these pieces a little blood vessel was noticed.

DR. STEWART—Was there much hemorrhage?

DR. REED—And how often did it occur?

DR. SMITH—A teacupful at the last occasion. As to frequency, it was generally at the time of her periods that the hemorrhage occurred; in the intermenstrual period it occurred very seldom and very slightly. The hemorrhage did not always amount to a teacupful.

DR. ENGLAND—Was there hemorrhage before the appendages were removed?

DR. SMITH—No. In removing the ovaries I noticed a subperitoneal fibroid on the back of the uterus, which I did not disturb, not wishing to complicate the operation. The appendages were very much inflamed and thickened, the ovaries also.

DR. A. LAPHORN SMITH read a paper on Tubercular Peritonitis, with report of a case treated by operation.

It is now three years since Dr. William Gardner read a most interesting paper before this Society on abdominal section for tubercle of the peritoneum and uterine appendages, reporting at the same time five cases with two deaths. We have had no discussion, as far as I am aware, on this most important topic since then, and as I had a case of the same kind to report, I wrote my paper so as to give an opportunity for a discussion on tubercular peritonitis in general, and the operative treatment of it in particular. Having seen a good many patients die from this disease, under treatment with medicine, some of which cases were diagnosed and some were not, and having made post-mortem abdominal sections of a good many children who died from this disease at the East London Children's Hospital during my term of residence there, I have always taken a great deal of interest in the progress which our knowledge of this obscure disease has been making during the last ten years, and especially in the wonderful results of abdominal section as a means of cure. How is the disease contracted? How may it be prevented? How may it be diagnosed? And what is the best treatment? These are all questions of great practical importance. I shall only attempt to throw out a few suggestions in reply to these questions, trusting that the professors of pathology, medicine, hygiene and abdominal surgery, who may be present, may give us from the abundance of their knowledge. In order to clear the ground for action, I would like to begin by expressing my utter disbelief in the heredity of this disease, no matter where situated, whether in the res-

piratory organs or in the digestive organs, or even in the joints. That a great many children are infected by their tubercular parents after birth is easy enough to understand, but that a child born of tubercular parents, but never exposed to infection, either by bacilli-laden air or bacilli-laden milk, could acquire tuberculosis, is a thing of which I have never seen or heard the slightest proof. Any evidence which has so far been brought forward on this point would prove much more easily that measles was a hereditary disease. This question of infectiousness is much more important than one might at first sight suppose. For, until the profession can be freed from the superstition of heredity there is little hope of tubercular diseases being stamped out, as they only can be by rigorous precautions against infection by the air or by the food.

If tubercular peritonitis then is not hereditary, as I hope no one here believes, by what means does the peritoneum become infected? Through the blood vessels or through the lymphatics? There would seem to be little doubt in the mind of pathologists that the lymphatics are the channels by which the bacilli gain admittance to the great lymph sac. The fact that the pleura and pericardium are connected with each other by lymphatics, and the frequency with which tubercular pleurisy and pericarditis exist as complications of tubercular peritonitis without the lungs being affected, together with the absence of bacilli in the blood, would place this contention almost beyond a doubt.

If this be the case, the bacilli must be introduced by the digestive or genital tract. Let us take first the digestive tract. Although theoretically a few bacilli might be swallowed with air, practically this would be a very rare cause of the disease. The large number of tubercular cattle which are killed on the farms or in small towns and even in private slaughter houses in large cities, so as to escape inspection, and the quantities of milk from tubercular cattle supplied to young children and others would furnish a bountiful supply of bacilli for the purpose of infection. Another method which might be termed auto-infection is that in which a patient with tubercular disease of the nose or mouth or larynx, or still more often of the lungs, swallows the discharge from these ulcerating surfaces laden with bacilli. They then pass through the absorbents and are at once grafted on to the peritoneal surface. Before long they are surrounded by phagocytes and are walled off by inflammatory exudation, so that they appear as little colonies or miliary tubercles. This process, however, at the same time causes adhesions of neighboring coils of intestine producing more or less pain, abdominal distension and interference with the processes of digestion. Strange to say, this does not always cause

fever; on the contrary, the temperature is often below normal.

In a large number of cases, 40 or 50 per cent. of the females at least, the disease has been found to co-exist in the tubes. At first, one might think that the disease in these cases had spread from the peritoneum down the fimbriated extremity of the fallopian tubes, were it not for the fact that in a large number of cases women have been known to suffer from tuberculosis of the vulva, vagina, uterus and tubes, without the peritoneum being at all infected. So that it is much more likely that the genital tract infects the peritoneum than that the peritoneum infects the genital tract.

The prevention of the disease depends most upon the detection and slaughter, at the expense of the country, of all the tubercular animals which might be used either for food or for giving milk, and the destruction of infected sputa from the respiratory tract of human beings. Only one step farther, though rather a long one, would lead us to the State undertaking the stamping out of the disease in human beings by the gathering together in a national sanitarium of all those who are at present acting as widespread centres of infection.

How to diagnose it is a more difficult question than any; so difficult, indeed, that it is rarely diagnosed at all. Dr. Gardner frankly stated in his paper that in only one of his five cases was the real nature of the disease suspected prior to the operation. The symptoms are very variable. There may be fever in some cases, while in others the temperature may be sub-normal. There may be very great or very little pain or tenderness. There may be diarrhoea or obstinate constipation. There may be effusion or there may be no effusion. There may be sweating, but this also may be absent. There may be tympanitis or the abdomen may be flat. There is generally nausea and anorexia, but occasionally the patient has a good appetite. There may be tumor-like formations due to adhesions of omentum and intestine, to the occurrence of which we are indebted for much of the increase in our knowledge of this subject, for it was in operating for supposed ovarian tumors, which they so much resembled, that the operative treatment of tubercular peritonitis was stumbled upon rather than invented. Pozzi mentions that out of 96 laparotomies in which this disease was found, in 37 of them ovarian or other tumors had been diagnosed. There are only two symptoms which seem to be constant, namely, rapid emaciation and great weakness.

Where so many diagnosticians have been deceived, the only sure means of making a diagnosis in all obscure diseases of the abdomen is to make a harmless exploratory incision, which will at once make the nature of the disease clear in the majority of cases.

Exploratory incision becomes a still more valuable means of diagnosis when we come to consider that at the same time, should the disease prove to be tubercular peritonitis, it is also the treatment which so far has given the best results.

The prognosis of tubercular peritonitis depends very much upon the treatment carried out. If treated by opium, as first advised by Stokes, of Dublin, in 1821, and afterwards by Graves, it was almost hopeless. Loomis, one of Clarke's disciples, says: "After weeks and months of anæmia and exhaustion, tubercular peritonitis terminates in death." Davis says: "All cases of peritonitis arising from tuberculosis are incurable. Temporary relief may be obtained by the removal of the accumulated fluid, by aspiration or tapping, but the diseases which have given rise to the peritoneal trouble, being themselves incurable, there is an inevitable tendency to a fatal termination." In Ziemmsen's Encyclopedia, and Pepper's System of Medicine, the prognosis is regarded as absolutely fatal.

But under the treatment by surgical operation, not too long delayed, the prognosis is already favorable, and bids fair to become much more so when abdominal section is resorted to earlier.

Does the operative treatment of tubercular peritonitis ever cure? This is a question which, during the last few years especially, has been a burning one. In the light of our present experience there can no longer be the slightest hesitation in answering it in the affirmative. In the words of Dr. Osler, the operative treatment of tubercular peritonitis is the most recent triumph of surgery. Kœnig, of Gottingen, gives an opinion founded on 131 cases, that by laparotomy 95 per cent. are much benefited, and 25 per cent. completely cured. Manoange gives 68 cases, of whom 13 died soon after operation, 15 disappeared, 14 remained alive at the end of six months and 26 at the end of twelve months. Homans records two cases with recovery. Goodell has operated on four cases, of whom three recovered and one died six months after the operation. Munde has operated on three cases with one death and two recoveries. Kelly gives four cases with four recoveries. Grieg Smith has operated on two cases with one death. Pitts reports three cases with three recoveries. Imlach reports five cases with four recoveries. These make a total of 222 cases treated by laparotomy with 84 recoveries, or 38 per cent. Judging from our experience in other departments of surgery, the result in the operative treatment of tubercular peritonitis will become much more favorable when the disease is recognized earlier, or when, in case of doubtful diagnosis, an exploratory incision is made, and no time is lost with unavailing treatment with medicine.

The surgical treatment of obscure intra-peritoneal disease is yet in its infancy. So far, as a rule, we have only been allowed to operate when all hope has been abandoned and the patients are *in extremis* with an enormously distended abdomen, thready pulse and cold extremities. There is a cause for every case of peritonitis, and if we know what that cause is we should operate to remove it; and if we don't know what the cause is, we should operate to find out. As J. W. Ross says, guessing at the cause from without the abdominal wall will not help us. We know that it is an operable disease, that an early operation is of the greatest value, while even in advanced cases it will frequently prolong life and possibly cure.

In one of Dr. Gardner's cases the abdomen was opened, inspected through a one and one-half inch incision, but nothing whatever was done; and yet the patient was decidedly improved, if not cured, by the operation. How can we explain a phenomenon which appears so inexplicable? The life history of bacteria, which is gradually being worked out by the devoted labors of the pathologists, appears to me to throw some light upon the mystery. The lower forms of fungi shun the light and air. Some of them may even be so delicate in this respect that sunlight and ventilation alone suffice to kill them. Not only in tubercular peritonitis, but in other forms of disease with effusion, the simple opening and drainage of the cavity has been noticed over and over again to have a very favorable influence on the disease. Lawson Tait says that he has seen tumors disappear, after laparotomy, in cases of disease of the liver, spleen and head of the pancreas. This has happened so often that it is impossible that it is a mere coincidence. He believes that the mere opening of the peritoneum has a direct influence in setting up the process of absorption. He thinks that some emphatic physiological change is at once set up by opening the peritoneal cavity, because there is a uniform onset of a most distressing thirst which lasts for days, and is not seen so markedly after other surgical operations. "Let the incision in the abdominal wall," he says, "be made down to the peritoneum, but let the serous cavity remain unopened, and this thirst is not marked; but let the peritoneum be opened but a finger's breadth and the result is marked." That a therapeutic change is effected in the peritoneum itself by the mere opening of the cavity is now universally recognized in the treatment of what we call tubercular peritonitis by abdominal section. This, however, is a question which I prefer to leave for fuller discussion to our pathologists.

I will now briefly relate my case, for in the words of Crofford, of Memphis, "The honest report of a single case will outweigh all the theory and speculation imaginable."

On the 22nd August, 1892, I was consulted

at the Montreal Dispensary for the first time by Mrs. S., aged 32, mother of three children, last child three years old. My clinical assistant, Mr. Harry, obtained the following history: Her family history was good and free from any trace of consumption, as far as she knew. She had always had fairly good health until two years ago when she was troubled with a soreness in her larynx or windpipe, which also prevented her from swallowing any solids, and for which she consulted Dr. Birkett. He treated her for several weeks with great benefit, since which she remained what she considered well until a few months before coming to the Dispensary, when she noticed that she was rapidly getting thin and her complexion was getting very dark, which she attributed to her liver being out of order. Occasionally the abdomen was sore and distended, and coitus and locomotion generally caused her pain. Menstruation had been scanty last two periods, and had not come on this time. During the last few weeks she had diarrhoea, and frequently felt hot and cold. She had no cough nor soreness of the throat, and her voice was very clear and strong. Her tongue was very coated, and her pulse 120, weak and almost dicrotic.

It is one of the rules at my clinic to take the temperature of every new patient, by which means acute febrile diseases are frequently recognized, which in the hurry of out-patient work might often escape detection. On this being done in this case, the thermometer registered 103 under the tongue.

The patient presented a very emaciated appearance. On vaginal examination, the cervix uteri was found to be lacerated on the left side and low down in the pelvis, while the left vaginal vault was fuller than normal and somewhat hard.

At the time she looked so like a typhoid case, that I ordered her to go home and go to bed, to take a hot water vaginal douche once a day, and to take no other food but milk. On calling at her home the next day, the temperature was the same. A careful examination of the abdomen revealed the presence of three rose-colored spots which disappeared on pressure. She still had diarrhoea, which was so profuse and painful that I was obliged to give her opium and camphor, and even that hardly stopped it. She was troubled with frequent micturition. There was also some abdominal distension, but there was no tumor to be felt, percussion giving, however, only a tympanitic note everywhere, for which I ordered turpentine stupes with considerable benefit. There was no dullness of the lungs on percussion, and auscultation showed that breathing was rather shallow and respiration a little prolonged.

During the next two weeks there was very little change in her condition, and I contented

myself with treating the symptoms as they arose. If she had had pain in the right inguinal region instead of on the left, I would have had no hesitation in coming to the conclusion that I was dealing with a case of typhoid fever, which at that time was rather prevalent in the city. Her temperature in the morning was nearly always a degree lower than at night.

After about two weeks, on making a morning visit, I found the temperature normal, and the skin, which had been hot and dry, was now bathed in perspiration. Although weak, she felt better in every way, and continued to improve for several days, so that I allowed her light farinaceous food in addition to the milk. As her temperature remained normal, I yielded to her request that I should allow her to sit up. I did not see her for several days, owing to absence from the city. On my return I found her back in bed with a high temperature and rapid pulse, and her abdomen distended and very painful on the left side. She also had a dry cough. She still had diarrhoea, for which I gave her bismuth, pepsine and a little morphine. There was only slight pain but no gurgling on the right side, but on making a little deeper pressure on the left side, I found the abdomen very painful and hard, and on making a bimanual vaginal examination, to my surprise I discovered the left vaginal fornix as hard as a board, into which hardness the uterus and left tube and ovary were firmly imbedded.

Notwithstanding the presence of so many of the symptoms of typhoid, I now felt convinced that the case was one of tubercular salpingitis, which indeed it probably had been all along, and I therefore urged immediate operation for its removal. To this, however, the patient would not consent. She was now placed on quinine and cod liver oil, alcohol and a generous diet, but her appetite remained poor until the oil was replaced with cream, after which she ate well. As she was under the impression that she would choke if she were to attempt to swallow any solid food, everything was cut very fine and, as far as possible, was first passed through a ricing machine.

Owing to her emaciated condition it was difficult to prevent bed-sores from forming in spite of every precaution. At last she found herself failing so much that she consented to the operation, which was performed on 24th October at her home, in which I was assisted by Dr. Ritchie and Mr. Smiley. The usual aseptic precautions were taken as far as her condition and the surroundings would permit, and she was easily anaesthetized with the A. C. E. mixture. Her abdominal wall was so thin that I cut through it layer by layer on the director, and it was fortunate that I did so, for the perietes and the omentum and intestines were all so intimately glued together, that had I made an

artistic single incision I should inevitably have cut through the bowels in several places, as indeed I once saw Olshausen himself do in a similar case. Even with this precaution I had difficulty in deciding when I had reached the peritoneal cavity. There was quite a thick layer of this organized lymph between the parietes and the omentum, but it was separated without much difficulty, when it became evident that the case was not localized in the appendages. In the right inguinal region there was a space the size of the palm of the hand where the omentum was not adherent, and the intestine could be seen to be covered with miliary tubercle. On the left side the omentum was very adherent to the abdominal wall right down to the inguinal region, but it was carefully peeled off until I was able to introduce two fingers down to the left tube as it came off the uterus. On attempting to lift the left appendages out in order to remove them, I found that they were in a broken-down and cheesy condition, the tube breaking off about three-quarters of an inch from the cornu. A few handfuls of caseous matter were then fished out; but the patient in her exhausted condition was too weak to bear any further prolonged manipulations without great danger, so the abdomen was carefully washed out with several gallons of sterilized hot water, a thin drainage tube was inserted, and the incision was sewed up with silk worm gut. A single hypodermic injection of morphia was administered, but after that she had little or no pain, not even the pain in the left inguinal region which she had had for some time before. The temperature also came down from 103 to normal, and remained there for the two days the tube remained in, but gradually rose again after its removal. A few ounces of blood were removed with a sucker during the next forty-eight hours, when the discharge becoming serous the tube was removed. During the next week she had frequently gushes of clear, water-like lymph from the vagina. She made such a nice recovery after the operation that I began to hope that she might eventually be restored to health, but two weeks and a half later she suddenly had a hemorrhage from the bowels amounting to at least a pint of blood. From that time she rapidly failed, dying a week later and three and a half weeks after the abdominal section. A post-mortem was asked for, but refused.

Although the result was ultimately unsuccessful, there is a good deal to be learned from the consideration of a case of this kind. First, there was the insidious onset of the disease. The patient had been in fairly good health ever since her treatment by Dr. Birkett for some affection of the larynx, until a few months before consulting me, and even then she only had the usual symptoms presented in women suffering from lacerated cervix. In fact, had I not taken her

temperature I would have had good reason to suppose that that was the cause of her abdominal pain, disturbance of digestion, etc. On the other hand, all the symptoms, the temperature included, pointed to typhoid in the second week. There was only one symptom partially missing, and that was the absence of pain and gurgling in the right inguinal region. There *was* pain there, but not so marked as on the left side. Then, again, after a period of defervescence during which the temperature remained several days normal and even below normal, the temperature arose as in a typhoid relapse, while the profuse hemorrhage from the bowels coming on three weeks later would have rendered this opinion more probable; had I not had the diagnosis of tubercular peritonitis made positive by the abdominal exploratory incision. Judging from the thickness and thoroughness of the adhesion, the disease must have been progressing for many months while the patient was going around and doing her work. Then, again, this point emphasizes the value of an exploratory incision as an aid to diagnosis in doubtful cases. Many cases of tubercular peritonitis are diagnosed and treated as typhoid. I regret very much that a large piece of caseous material which represented the left tube, and which I laid aside for microscopical section and examination for tubercle bacilli, was thrown away by the nurse. However, that might have been negative in its results, for it does not always follow that the bacilli will be found,—in fact, it is the exception to find them in undoubted cases of tubercular salpingitis. They are probably destroyed by the phagocytes, leaving nothing but the caseous debris of dead cells and bacilli. Another interesting question is this: Did the disease originate, or, to be more definite, was the infection introduced by the *genital* tract and carried up the vagina, uterus and tube to the peritoneum? or were the bacilli introduced from the *digestive* tract into the peritoneum and thence into the tube? Numerous cases of both these methods of infection have been recorded. Some maintain even that the spermatozoa from a tubercular husband may contain the bacilli; but the husband in this case was very healthy, and it seems unnecessary to fall back upon this hypothesis when there are so many easier ways for a woman to become infected. This may occur either with tuberculous sputa from her own or her husband's or her neighbors' lungs by means of her, his or their fingers or soiled handkerchiefs. In view of the fact that so many are so biased by the doctrine of the heredity of consumption that they cannot recognize its terrible infectiousness, it is rare that precautions against infection are taken. There are but few out of the thousands of tuberculous husbands, I fancy, who take the precaution of disinfecting their hands and penis before having sexual intercourse. According

to Winkle, 50 per cent. of the cases of tubercular peritonitis are infected by a tubercular salpingitis, and the early removal of the diseased tube would have prevented it. The rest of the cases of tubercular peritonitis are infected by means of the digestive tract, the tubercle bacilli passing directly from the stomach and intestine into the peritoneal cavity. The bacilli may have been swallowed with infected meat or milk, which is probably the commonest method of all when the lungs are not affected, but more often still when the respiratory tract is primarily attacked the bacilli are swallowed with the sputum in large numbers. This was undoubtedly the source of infection in my case. Dr. Birkett probably treated her for tubercular laryngitis, and cured her, but the cicatrix led to some distortion of the epiglottis which caused her difficulty in swallowing. At the time, she swallowed enough bacilli to infect the peritoneum, and the disease slowly progressed ever since without the symptoms being at any time sufficiently marked to call urgent attention to them.

Whence came the hemorrhage from the bowels? Doubtless from the ulceration of a tubercular focus eating through a large vein or artery in the wall of the intestine, just as the same thing happens in tubercular disease of the lungs, and just as occurs in the ulceration of Peyer's patches in typhoid fever. That perforation of the bowels was *not* followed by fecal extravasation, as generally happens in the perforation of typhoid, can be easily explained by the presence of a vast amount of dense adhesions in tubercular disease, contrary to what is the case in typhoid, by which means the area about to be perforated by the tubercular ulceration is walled off from the rest of the peritoneal cavity.

If my brief résumé of our present knowledge of tubercular peritonitis should draw forth some remarks from those here who are more able to instruct you than I, and if the report of my case will lead to you all come to a more speedy diagnosis and to adopt earlier what I believe is the only proper treatment, my very imperfect paper will have fulfilled the purpose for which it was so hastily written.

Dr. ADAMI held that in this case, probably all would agree that infection had occurred through the intestinal tract—the most usual cause of tubercular peritonitis. While infection could, and did, without doubt, originate through the genital passages in the female, he feared that obstetricians were wont to attach too much importance to this channel. Tubercular peritonitis is most frequent in children, and here there can scarcely be question of infection per vaginum.

With regard to operative treatment as a means of diagnosis, he agreed with Lawson Tait,

“When in doubt perform a laparotomy.” It must, however, be remembered that in a very large proportion of cases, tubercular peritonitis tends to be very chronic, nay more, not infrequently it tends to spontaneous cure or, rather, arrest. The explanation of its frequent slow course, especially in children, is to be found in its connection with the milk diet of those affected. As Bollinger, Bang, Woodhead and others have proved, there is an intimate association between tuberculosis in the cow and the tubercular peritonitis in children.

Dr. ADAMI dwelt to some length upon the nature of this tubercular disease in the cow, and pointed out the frequent difficulty in diagnosing the same. He indicated that by centrifugalizing the milk, the bacilli could be determined with comparative ease, while diagnosis might be aided by the employment of Koch's tuberculin. It has of late been fairly satisfactorily proved that tubercle bacilli from different animals possess different degrees of virulence; there are, in fact, varieties of the bacillus in question, and cultures obtained from the cow are of less virulence than those obtained from cases of acute tuberculosis in man. In this way, he considered, might be explained the milder nature of many cases of tubercular peritonitis, especially in children. It is not uncommon, in conducting autopsies upon children of twelve years of age and over, to find that the peritoneal cavities are perfectly sound, yet certain of the mesenteric glands are cheesy, indicating a condition of tuberculosis that has passed off, leaving but these traces.

With regard to Dr. SMITH's explanation of the fact that opening the abdominal cavity may lead to cure, Dr. ADAMI could not agree with him that simple ventilation of the cavity was the cause. He was of opinion that a far more likely cause was to be found in the irritation induced by the operation, and washing out—the inflammation set up in excess of what obtained previously. With this might be compared the increased inflammation and increased absorption that accompanied the injection of tuberculin, etc.

Dr. REED expressed his pleasure at listening to Dr. ADAMI's remarks. He noticed that in the *British Medical Journal* of this week, one or two points mentioned were in a line with the opinions of Doctors SMITH and ADAMI. Several eminent men. Robson and others, said cases with a good deal of dropsy were most likely to do well, and that those cases which were most likely to do well after laparotomy were most likely to do well without it. Supposing, of course that a patient has tuberculosis of the larynx, it is more than simple peritoneal tuberculosis, and the prognosis would be worse.

To be continued.

Progress of Science.

INTERNES COOK COUNTY HOSPITAL, CHICAGO.

The Annual Competitive Examination for the positions of interne at this institution, one of the largest hospitals in this country, was recently conducted by thirty members of the Regular Medical Staff.

An examination of the records shows that of the thirty-one competitors twelve were students of Rush Medical College, nine of the Northwestern University Medical School (Chicago Medical College), nine of the College of Physicians and Surgeons, and one of the N. W. Univ. Woman's Medical School.

The eight positions were secured by E. H. Tinon, F. A. McGrew, R. B. Oleson, J. J. Claussen, G. W. Skinner, T. J. Williams, T. P. Findley and T. A. Olney, in the order named.

Representatives of Rush Medical College secured 1st, 2nd, 5th, 6th and 8th (five) places; Chicago Medical College, 3rd and 7th (two) places; College of Physicians and Surgeons, 4th (one) place.

Internships in this hospital are among the most valuable positions obtainable in this country, and, as they are very earnestly competed for by the best students of the different medical schools in that city, the gentlemen securing positions are to be congratulated.

BUREAU OF INFORMATION AND SERVICE FOR DOCTORS ATTENDING THE COLUMBIAN EXPOSITION.

Doctors from all parts of the world visiting the Columbian Exposition in Chicago, opened on May 1st, should keep in mind, as valuable information for themselves, that Messrs. Chas. Truax, Greene & Co. have authoritatively established a Bureau of Information and Service for the purpose of aiding doctors to secure board, etc. They also provide a sitting room, a reading room, etc., and will cheerfully furnish such information as they can about the Exposition, etc.

ASSOCIATION OF AMERICAN MEDICAL EDITORS.

Will hold its Annual Session in Milwaukee, Wis., Monday evening, June 5th. The *Journal of the American Medical Association*—the editor of which is President of the Association—inform us that the officers have resolved to make a great effort during this session to per-

fect the organization, and have every regular medical journal in the country represented; also to create renewed interest in medical journalism, etc. Hence Mr. Ernest Hart, the distinguished editor of the *British Medical Journal*, has been invited to deliver an address. Dr. J. Stanley Hall, president of Clark University, at Worcester, Mass., one of the editors of *Journal of Psychology*, and in charge of the most complete laboratory for psychological research in America, will also address the Association, probably on some psychological point. We so thoroughly recognize the value of an Association such as Dr. Culbertson wishes to make this that we most cheerfully proffer our cordial help.

PROFESSOR OSCAR LIEBREICH ON MINERAL WATERS.

The *British Medical Journal* reports that in a paper on Artificial and Natural Mineral Waters, read by Professor Oscar Liebreich at the Balneological Congress recently held in Berlin, he began by asking: Is chemistry sufficiently advanced yet to produce artificial mineral water equal in all respects to the natural water? The answer is negative. The artificial production of mineral waters is a much more difficult matter even than the production of such substances as alizarine, indigo, etc., and the analyses, even of the most renowned analysts, fall short of the full contents of the water. In the natural mineral water, on evaporation, there is always a residuum which is not contained in the analyses of the artificial mineral waters. The carbonic acid gas which furnishes the effervescence of natural mineral waters exists also in the form of "carbonic acid hydrate." This has been inferred from the existence of another combination derivative from it, namely, carbonic acid ethyl, which is probably contained in champagne and in other alcoholic effervescing drinks, and is known for its agreeable taste. It may be supposed that the action of an hydric carbonic acid gas is different from that of carbonic acid hydrate. "Even the best manufactured mineral waters," Professor Liebreich points out, "differ from the natural ones in taste and value; this difference it is not so easy to explain." He concludes by observing that: "As to the so-called 'indifferent' springs, it is a mistake to speak of them as of minor value." It must be remembered that they, too, contain mineral ingredients, if only in minimum quantities, which counteract the harmful properties of perfectly pure distilled water. Even hydropathy is a mineral water treatment, for if the water used were without traces of mineral substances it would be poisonous. This has been sufficiently proved elsewhere.

CEREBRO-SPINAL MENINGITIS.

In the spring number of *Brain*, 1892, Trevelyan records thirteen cases of the non-epidemic disease with eleven necropsies. In no case was tubercle found after death, and in only one instance was there otorrhœa during life. The occasionally rapid course of the disease, and the ease with which it may be overlooked, are referred to. Under the morbid anatomy it is pointed out that the chief seat of the disease is in the subarachnoid tissue, and that the exudation is most plentiful in the dorsal and lumbar regions of the cord, because this tissue is most abundant there, whereas there may be none in the cervical region. The character and extent of this exudation in cases which recover are discussed, and the importance of a more systematic examination of the cord dwelt upon. Of the thirteen cases, six were examples of the primary disease, two complicated acute pneumonia, one was associated with proliferative endocarditis, and in another case these three diseases existed together. The relationship of these diseases is then discussed, and the probability of the same *materies morbi* (as, for instance, the pneumococcus infection) being able to produce them is referred to. No bacteriological investigation was made in these cases. In a most rapidly fatal case (ix) the disease supervened on diphtheria. The occurrence of cerebro-spinal meningitis after such infective diseases as enteric fever, measles, influenza, is next illustrated. In Case XII profuse otorrhœa occurred in the course of the meningitis, and at the necropsy no bone disease was found. The possible spread of the inflammation from the meninges to the middle ear is then alluded to, and the mode of origin of meningitis secondary to ear disease without any bone affection touched upon. Cerebro-spinal meningitis after head injuries, but without fracture, is next referred to. Case XIII was an example of the disease occurring after a comparatively trivial operation on the throat. Other such cases are cited, and an explanation of the connection, if any, between the events sought for.—*Med. Press.*

PROLAPSE OF THE EXTREMITIES IN HEAD PRESENTATIONS.

J. Kaeser (*Centralbl. f. Gynäk.*, No. 2, 1892), from a study of recorded cases, finds that prolapse of the extremities is far commoner in multiparæ than in primiparæ. The complication is favored by hydramnion, contracted pelvis with previous heavy labors and twin gestation, since in these conditions the inferior uterine segment does not press on the head with

firmness sufficient to prevent prolapse of the extremities. Prolapse of the arms is less serious than prolapse of the legs, but the cord often comes down as well in these cases, and that condition is very grave for the child. When the membranes are yet entire the obstetrician must wait till the os is completely dilated. Then the protruding extremity must be pushed up, and the head brought well down by external pressure. After rupture of the membranes, manual reposition of the prolapsed member must be effected; if this prove unavailing and the head is movable, it will in many cases be advisable to turn. When the head is firm, reduction of the extremity should be cautiously attempted in the intervals between the pains. If this should fail, then, according to the nature of the case in other respects, natural evolution may be awaited, or the forceps or perforator may be required.—*B. M. Journal.*

INJECTION OF SALINE SOLUTIONS.

Kortmann (*Deut. Med. Woch.*, April 21st, 1892) refers to over-distension of the venous system and other dangers from intravenous injections in cases of acute anæmia due to loss of blood, as well as to the want of success so often attending them. It is recommended to inject some 600 g. of a warm 6 per cent. sodic chloride (sterilized) solution into the outer side of the thigh, the needle being inserted well under the fascia ("parenchymatous injection"). A syringe holding 100 g. with a long needle provided with a stopcock, is made use of. It has been proved that absorption takes place rapidly from the subcutaneous tissue in the case of loss of fluids to the body. The circulation must, of course, be going on, but even in desperate cases with hardly any pulse such absorption will take place. In these cases it might be well to inject 100 g. into the veins at first, and then to proceed with the other method. The author gives the details of 11 cases, 6 of which were treated with intravenous injections, and the 5 remaining ones with these parenchymatous injections. Only one of the former recovered, whereas of the latter only one died. With one exception, they were all cases of hæmorrhages after very severe operations upon patients, many of whom had already lost much blood. The author is of opinion that, in all cases of acute anæmia consequent upon internal hæmorrhage, intravenous injections are contra-indicated on account of the danger of the rise of blood pressure producing further hæmorrhage, and that here subcutaneous or parenchymatous injections should alone be used. The latter methods are simple and without danger.—*B. M. Journal.*

HYDROGEN PEROXIDE AS A THERAPEUTIC AND DIAGNOSTIC AGENT.

From a large experience with this drug, Stuver (*Therap. Gazette*, March, 1892) draws the following conclusions:—(1) A reliable solution of hydrogen peroxide is an efficient and safe germicide; (2) by its oxidizing power it rapidly decomposes pus, diphtheritic membranes and other pathological decayed deposits and effusions; (3) it is an excellent deodorizer, and a non-irritating cleansing agent for foul wounds, abscesses, etc.; (4) it is a valuable diagnostic agent in determining the presence of pus, for, when injected into a part in which suppuration is suspected, it will indicate pus if present by causing almost immediate tumefaction. When employing the drug in this way the surgeon must be prepared at once to use the knife should his suspicions prove correct, as thereby pain will be avoided. A number of suppurating buboes treated by the author did admirably under this method.—*Current Medical Literature*.

PERICÆCAL ABSCESS.

Mr. Edmund Owen operated on a young man, æt. 18, who had just been admitted into the hospital under Dr. Broadbent for an obscure abdominal affection. The history was that the patient had suffered from "inflammation of the bowels" last June, and that he was again in trouble in August with hypogastric and vesical pains; also that, being a plumber, he had been treated, according to his account, for lead colic. He looked very ill, and complained of piercing pain in the right inguinal region; temperature 102° F. As he lay on the table, Mr. Owen pointed out in the right iliac, hypogastric, and also in the right lumbar region, a great hardness and fullness, which felt as solid as a sarcoma, but its extreme tenderness suggested the swelling being of an inflammatory nature. Mr. Owen gave it as his opinion that the source of the trouble was perforation of the vermiform appendix. He made a free incision over the most prominent part of the tumor, which was about 2 in. to the inner side of the front of the iliac crest, and having traversed the abdominal wall, called attention to the fact that the muscles were so sodden with inflammatory effusion as to be about 2 in. thick, and that this apparently constituted the chief part of the hardness and swelling. Having cut a little deeper still, he came upon two encysted abscesses, which, to the onlooker, seemed to be very deeply placed in the iliac fossa. He remarked that all the tissues were so matted and sodden as to be incapable of recognition, and that he should be content with washing them over with hot iodine water, and draining them. He said that inquisitorial handling was not only

uncalled for, but that it might lead to the inflammatory bounds of the suppurating cavity being broken down and to the general peritoneal cavity being implicated. Dr. Broadbent said that he was entirely satisfied with the procedure, also that his opinion had been that pus was lurking in the neighborhood of the appendix, and that unless an outlet were surgically provided for it through the thickened tissues, there was a great risk of its promptly finding an escape into the peritoneal cavity. It is satisfactory to state that, as the result of the operation, the patient's temperature has fallen more than two degrees, and that he has greatly improved in every respect.—*Med. Press*.

THE SURGICAL TREATMENT OF UTERINE CANCER.

The impunity with which large operations can now be done by careful surgeons is, doubtless, the cause of the tendency complained of that they, or some of them, too readily have recourse to extensive mutilations when the relief of the patient might be obtained by less drastic and less dangerous measures. This is especially the case in respect of the surgery of the uterus, and at the last meeting of the Royal Medical & Chirurgical Society, a protest was entered against the wholesale recourse to hysterectomy, for which certain Continental, more particularly German, surgeons have become notorious. Cancer of the uterus may be roughly divided into two classes, according as the disease attacks the body or the cervix. Not even the most conservative surgeon would be disposed to question the propriety of total extirpation in the former, and the battle is being waged over the course to advise in the treatment of cases in which the disease appears to be limited to the cervix. For purposes of discussion a further division is necessary, because the disease may start either in the vaginal portion of the cervix or from the cervical canal, attacking the tissue of the cervix proper. The distinction is important, because, while in cancer of the vaginal portion of the cervix the diagnosis is easy, and can be made early in the case, owing to the part being within easy reach and readily accessible to inspection and operation, the diagnosis in the latter must remain for some time a matter of inference. Hence, by the time the symptoms justify recourse to operative procedures, the malady has had time to infiltrate the neighboring tissues. It may be remarked that the tendency of cancer in this situation is to spread laterally, and when it is found to have reached the level of the internal os, or the body of the uterus, there is reason to suspect that the disease lower down has advanced beyond the reach of treatment. In this class of cases, therefore, nothing short of total extirpation would seem to hold out hope

of freedom from recurrence. There remains the question of the best treatment for cases in which the disease is limited to the cervix, and has been diagnosed before the neighboring tissues have become too extensively infected. Many surgeons, anxious to guarantee as far as possible against recurrence, make a practice of performing total hysterectomy in every case of cancer of the uterus; but in this country the operation known as supra-vaginal amputation of the cervix is more frequently practised, and with results that seem to justify the claims advanced in its favor. This operation gives a mortality of not more than four per cent., and appears to give very fair protection against recurrence. In the hands of Dr. Lewers and Dr. Jessett, indeed, the results may be described as brilliant, the more so, seeing that, so far, Dr. Lewers has not had a single fatality in nineteen cases. At first sight, a comparison in the mortality following the two operations would seem to settle the question as to which is to be preferred, but there is the difficulty that the figures do not apply to strictly comparable classes of cases. Abroad, hysterectomy is performed for cancer of the uterus in every degree, and even for displacements and other non-malignant diseases of that organ. It is obvious that for purposes of comparison such figures are useless, though as far as they go they emphasize the preference to be given to the milder operation. Hysterectomy done for cancer is a very different operation to hysterectomy done for non-malignant disease, and the less advanced the disease the greater are the patient's chances of recovery. It must, therefore, be clearly understood that for purposes of comparison, statistics bearing on hysterectomy for cancer, and for cancer only, are admissible. Even with all these favorable circumstances the mortality of total extirpation as practised abroad averages from fourteen to sixteen per cent. and upwards, a proportion of deaths which would only be justifiable assuming that the operation was in every instance undertaken for extensive disease, which, as we have shown, is not the case.—*Med. Press and Cir.*

CHRONIC PROGRESSIVE HEREDITARY CHOREA.

In the *Deut. Med. Woch.*, June 23rd, 1892, Schmidt observes that the chief distinctions from ordinary chorea are that the progressive disease occurs later in life (from 30 to 40), that it is progressive in character and accompanied by mental change, and that it is the result of direct inheritance and is incurable. The two cases recorded here by the author occurred in sisters, and differed from the usual cases in (1)

the age of the patients and (2) the absence of any question of direct inheritance, although there was a neuropathic family history. It has been said that if a generation be skipped the disease does not appear in later generations. If, however, epilepsy and simple psychoses be regarded as equivalent types of disease, then heredity must hardly be looked upon in this narrower sense. The elder, aged 16, first had movements affecting the head, mouth and tongue, when she was 7 years old. She was able to remain at school until she was 14. Then the disease steadily increased. When seen, the patient's intelligence was somewhat deficient, the speech difficult, and the gait stumbling. The movements were choreiform in type and sometimes extended to the hands. They became rather less marked on voluntary exertion, and ceased during sleep. Fatigue and mental excitement aggravated them. There was no local paralysis and no impairment of sensation. The knee-jerks were present. There was slight nystagmus. The younger sister, aged 14, was also well up to the age of 7 years. The movements affected the head and face, but they were less marked than in the sister. There was also some mental weakness. Whether this progressive disease is to be sharply separated from ordinary chorea can hardly be stated at present considering the obscurity of the pathological anatomy in both affections. Voluntary movement lessens the spasm in the hereditary disease, but not so in ordinary chorea. Sleep does not always entirely stop the movements in the former disease.—*Brit. Med. Journ.*

ANTINERVIN.

This product is now reported to have a much wider field of usefulness than a year ago. Observers give good reports from England, Germany and Italy. In Glasgow, Scotland, it attracted much attention in the recent epidemic of influenza. It nearly always relieved the pains in the back and head, and rapidly reduced the fever. It produced copious perspiration and no unfavorable effects.

Dr. G. Laurenti, of Italy, now summarizes his own personal experience: (1) It can be used with advantage in all forms of abnormal excitement of the nervous system, whether to subdue neuralgia or as a general nerve sedative; (2) in rheumatism it may be used, and seems undoubtedly indicated as a drug comprising in itself anti-rheumatic, antipyretic and analgesic properties; (3) its low price and feeble toxicity, together with the evidence already given, render it a useful addition to our list of remedies.

Practically nothing has been written upon it in this country during the past year, and it may be

hoped that a good reason may be furnished to account for this inattention in that we obtain fully as satisfactory results by administering the ingredients in proper proportions made up into an extemporaneous prescription, or otherwise dispensed separately.—Squibb's *Ephemeris*, February, 1893.

TREATMENT OF HEADACHES.

Collins (*Med. Record*, April 2nd, 1892) leaving out of consideration migraine and neuralgia, adopts Dana's classification, with a few modifications, based on the etiology of headache, namely, 1. hæmic: (a) anæmia (b) hyperæmia, (c) diathetic states (gout, rheumatism, lithæmic and auto-toxæmic conditions); (d) infections; (e) uræmia, dial. etes. 2. Toxic: lead, alcohol, tobacco, drugs. 3. Neuropathic states: epilepsy, neurasthenia, chorea, hysteria, etc. 4. Reflex: ocular, dental, naso-pharyngeal, auditory, dyspeptic, sexual, uterine, etc. He considers that the salicylates and chloride of ammonium rank first among medicinal agents. Salol or salicylic acid is the best form in which to give this remedy, and it is of most importance in diathetic, toxic, and auto-toxæmic states. It is of advantage to combine this drug with a mineral acid in these conditions, as the latter prevents the formation of uric acid compounds. Chloride of ammonium is particularly useful when headache is associated with loss of appetite, sickness, bad taste in the mouth, flatulence, stuffiness of the bronchial tubes, etc., and should be given in the form of wafers containing ʒss to ʒj every two to four hours for three doses. Headaches dependent on diminished blood pressure are frequently relieved by sipping, for example, taking a glass of cold water by mouthfuls. Mastication, sniffing irritant substances, exposure to cold, and excitement serve the same purpose. The action of cardiac neurotics is evanescent, particularly the diffusible stimulants, which have the additional disadvantage of often leading to the formation of a habit. Where congestion is the cause ergot should be given internally, and derivatives applied to the extremities, or the external application of cold, frequently assisted by a dose of bromide, is of service. Galvanism to the cervical sympathetic also frequently gives relief. When it depends on stomachic hyperacidity without constipation, bicarbonate of soda gives relief; but when sluggish digestion with constipation is present, acids and simple bitters should be used. In reflex headaches the cause must of course be removed. Collins considers that the employment of the recently introduced

coal tar products such as antipyrin, etc., is to be avoided, as, while relieving transitory neuralgic headaches, they exert no influence on the cause. The treatment between attacks consists in preventing and overcoming every perverted condition on which the pain may depend, and building up the system. One measure is especially of use, namely, water, both internally and externally, but especially the latter. Those headaches which are dependent on hæmic and vascular changes are most benefited by the application of cold water in the form of shower, plunge, or needle bath, etc.; while those dependent on neuropathic conditions derive most good from the cold pack.—*Brit. Med. Jour.*

EASY LABORS IN CASES OF CONTRACTED PELVIS.

Tarnier (*Journal des Sages Femmes*, April 16, 1892) warns his pupils against the fallacy that because a woman has had three or four easy labors the next future labor will certainly be easy. The contrary is often the case. Every day we see instances of women with a conjugate of 6 centimetres ($3\frac{1}{2}$ inches) delivered spontaneously. After four or five such labors the next proves difficult. The explanation is not always easy; probably the size of the foetal head had not been estimated or measured; proving larger in the last than in earlier labors. When a student, Professor Tarnier once was summoned to a case, and found a big baby in a cradle. It was big when born the mother said. On examining the mother, who was in labor, he found that the pelvis was contracted. The previous child had been delivered spontaneously. The labor in hand proved very difficult, and could not be concluded without the use of the cephalotrite.—*Brit. Med. Jour.*

TOTAL ABSENCE OF MENSTRUATION IN A PATIENT AGED 24.

H. W. Mitchell (*N. Y. Medical Record*, March 19th, 1892) has had this case under his observation since April, 1889. The patient was born in Ireland, and emigrated to New York in March, 1888. Up to that time she had never so much as heard that such a function as menstruation existed. In New York she became a domestic servant, and her colleagues found out that she never menstruated. They told her that all sorts of evil results, ending in insanity, would follow. For the first time, she became ill and nervous. On April 7th, 1889, Dr. Mitchell examined her. The pelvic viscera appeared to be perfectly heal-

thy. He told her that her condition was compatible with perfect health, and she soon recovered her former good spirits. Iron and other tonics were given, but the menses have never appeared. In January, 1892, she was again examined. Her weight was 105 lbs., and it appeared that she weighed 25 lbs. heavier before leaving Ireland. There was, however, no sign of phthisis—indeed, all the viscera appeared healthy. In figure she was erect, plump, and symmetrical. The mammæ were well developed, firm and round; the nipples small, with no areola. The vagina was short, the cervix very small, projecting but slightly into the vaginal canal. The depth of the uterus from os to fundus was $2\frac{1}{4}$ inches, or nearly normal. The mons veneris was almost destitute of hair, and the labia ill-developed. As far as could be ascertained, the sexual instinct was entirely absent. The patient's general health was excellent.—*Brit. Med. Jour.*

GAUZE COMPRESS LEFT BEHIND IN ABDOMINAL CAVITY AFTER OVARIOTOMY.

Salin, of Stockholm (*Centralbl. f. Gynak.*, No. 24, 1892), uses, instead of sponges, sterilised gauze compresses. On October 31st, 1890, he removed an ovarian tumour from a woman aged 55, who made a good recovery. At the end of the summer of 1891 she complained of swelling to the left of the hypogastrium. At the end of October, one year after the operation, an abscess formed in the lower extremity of the abdominal cicatrix. On November 7th it opened spontaneously, and a great quantity of foetid pus escaped. A swelling, not very tender, was detected on bimanual palpation, to the left of the uterus, and a sound could be passed towards it from the orifice of the fistula in the abdominal wound. This fistula was dilated with plugs of iodoform gauze, then some threads came away. On inspection they proved to be cotton, not silk, so that they did not arise from the pedicle ligatures. The fistula was enlarged with the knife, then a gauze compress was discovered and removed. On the next day much fæulent fluid, evidently the contents of the small intestine, came away through the wound. Gradually this fæcal fistula began to close. It was believed that a compress had been unwarily cut in two during the operation, so that the full number was counted though one compress still remained behind.—*Brit. Med. Jour.*

OPENING OF THE MASTOID PROCESS IN MEDIAN OTITIS FOLLOWING INFLUENZA.

Politzer (*Ann. des Mal. de l'Oreille*, May, 1892) found mastoid inflammation of common occurrence during the two later epidemics of influenza. The form of mastoid process most

frequently affected was the "pneumatic," in which numerous cells communicate with each other and the antrum by very small openings. Such openings become closed by inflammatory swelling, and a pent-up collection of pus results. Politzer found such abscesses "in the middle or inferior segment of the vertical portion of the process, notably in the superficial cells situated under the cortical layer of bone." In most cases the tympanic suppuration had already ruptured the membrane, otherwise the ordinary symptoms of that condition were present. The special symptoms of mastoid implication observed were lancinating local pain radiating in various directions, tenderness on pressure or percussion on the mastoid, local and general rise of temperature. The tympanic membrane may bulge, and postero-superior wall of the meatus may be pressed downwards into the passage. The course of mastoiditis following influenza is much less likely to end in resolution than ordinary cases, it occasionally opens externally of itself, it tends to cause destruction of bone and to lead to serious sinus or brain complications. The treatment of influenzal median otitis varies with the stage of the disease. In the earliest days and before the membrana tympani has given way, paracentesis should be performed, and ice or Leiter's cold coil applied to the mastoid. If the mastoid symptoms have lasted with intensity for eight or ten days, the mastoid should be opened in addition. If perforation of the tympanic membrane has occurred in the early days, antiphlogistic means (ice or Leiter's coil, iodine, counter-irritation) should be adopted, and with them should be combined boracic irrigation of the tympanum by catheter through the Eustachian tube. Should the intensity of the symptoms not then diminish within three or four days the mastoid should be opened. When we are called to a case in which symptoms of mastoiditis have existed for two or three weeks no delay is permissible. Operation by means of a gouge is recommended. Often the abscess is found under the superficial layer of bone, not communicating with the antrum. Politzer insists that on no account should an artificial communication be made in these acute influenzal cases, unlike what holds good in ordinary chronic otitis.—*Current Med. Lit.*

RADICAL CURE OF VENTRAL HERNIA.

Pitschke (*Centralbl. f. Chir.*, No. 24, 1892) reports a case in which he performed, with good prospects of ultimate success, an operation for the radical cure of a large ventral hernia.

The patient, a female aged 61, presented a swelling which reached from the lower third of the abdomen on the right side almost to the

knees. This was a hernial protrusion, containing readily reducible intestine and omentum. The mouth of the sac, measuring about 6 inches in diameter, was situated a little below the level of the antero-superior spines of the ilium. The coverings of the hernia consisted of attenuated skin and muscle, which, after reduction of the contents of the sac, formed large dependent folds. There were also two inguinal herniæ—a large one on the left side, which necessitated the wearing of a truss, and a smaller one in the right groin, which came down only after reduction of the ventral hernia. The large central swelling had existed for about three years. It had first increased in size slowly; but after a time, in consequence of violent muscular exertion, suddenly enlarged, and subsequently continued to descend with greater rapidity. The patient could not tolerate the pressure of a truss on this hernia, which, as it increased in size, became more and more irksome. The frequently-renewed contact of urine and fecal matter caused a painful and obstinate excoriation of the skin on the lateral and posterior surfaces of the swelling, which, together with the weight of the hernia and its protrusion between the thighs, led the patient to seek urgently for surgical relief. After reduction of the contents of the hernia, a long incision, which exposed the interior of the sac, was carried through the abdominal wall from above, downwards, and inwards as far as the greater labium on the right side. The thick and strong peritoneal wall of the sac was then dissected away from the superjacent soft parts, during which stage of the operation the intestines were retained within the abdomen, and guarded by a large pad of antiseptic gauze. The dissection was carried as far as the mouth of the sac, and the portion of peritonium forming the neck then constricted by silver wire. After this the body of the sac was excised, and the free margins of the stump were brought together by catgut sutures. It was found impossible to bring together the thin fibrous and muscular margins of the opening in the abdominal wall. The surrounding structures, however, and the edges of the wound on the skin, were closely applied by numerous sutures. During the first three days after the operation the patient suffered much from frequent vomiting, with obstinate constipation, which excited a suspicion of intestinal obstruction. Those disquieting symptoms ceased after the administration of a copious enema; and the patient subsequently made a good and uninterrupted recovery. The wound healed by primary intention, and when the woman was last seen by the author, twelve months later, there was complete freedom from ventral hernia, and an absence of any protrusion, even on coughing, at the seat of the operation.—*Current Med. Lit.*

A SUBSTITUTE FOR DECALCIFIED BONE IN SENN'S DISCS.

Baracz (*Centralbl. fur Chir.*, No. 23, 1892) states that in experimenting with Senn's discs, the idea struck him that decalcified bone might be replaced by some other and more readily available material, which could be used by the practical surgeon without much preparation, and, consequently, with less trouble. After trials of numerous edible vegetables, such as potatoes, turnips, and carrots, from which sections of firm, flexible and moist discs can be obtained, the author found that the most suitable substance for his purpose was afforded by the Swedish turnip. Sections of this vegetable, it is stated, form a reliable material for use in gastro-enterostomy, and in establishing intestinal anastomosis, and one which can be more readily obtained and prepared than decalcified bone. That sections of fresh turnip present a trustworthy substitute for decalcified bone is shown by the results of the author's experiments on animals, and also by the success of an operation for gastro-enterostomy which he performed on the human subject early in May. The results of this operation, which was performed for the relief of carcinoma of the pylorus, had, up to the date of the publication of this paper, been very favorable.—*Current Med. Lit.*

IS THERE ANYTHING NEW UNDER THE SUN?

Was Cyrus acquainted with bacteriology? If not, how did he learn to boil his water? Herodotus, in his First Book, chapter 188, tells us that "Cyrus went up to battle, richly provided with goods and cattle from his own land, and he also took with him the water of Choaspus which flows by Susa. And the King had this water served at table, and no other, which was *boiled*; it was transported in silver vessels, borne on a four-wheeled carriage and drawn by mules." On his march Cyrus must have passed through many districts where little or no water could be obtained on his way to Capdus, and this would of course necessitate his carrying supplies on long marches. From the context we are informed that it was the custom to boil the river waters in Babylon before using them. Did instinct, experience or scientific knowledge prompt the Babylonians to sterilize drinking water 550 years before the birth of Christ? It is a pity the classics are now falling into such disfavor as a part of the medical student's training or some further light might be shed over the enzyme theory by the mature experience of our forefathers, though viewed by man as a *parma non bene selecta*.—*Medical Press.*

THE CARBOLIC SMOKE BALL.

The fashionable world are familiar with advertisements in the "Society" papers of a beautiful young woman holding to her nose what looks like an ignited bomb-shell, and if they have read the printed context (which few do) they must have learned that this bomb-shell is a sovereign cure for all sorts of laryngo-tracheo-naso-bronchial ailments, and that if they smell the bomb-shell without immediately getting well they can claim £100 from the proprietors of the article. Promises of this sort have been made millions of times by thousands of traders, and have been read by tens of millions of persons, but no one ever took them *au sérieux* until a few months ago, when a feminine purchaser invested in a bomb-shell and smelled it for three whole months with abiding faith, but so far from being cured of her cold, she acquired active influenza. She accordingly sued to recover the £100, and the Company resisted on the ground that there was no contract to pay, there being no formal acceptance of the bargain by the plaintiff, and also on the plea that the plaintiff should have attended thrice daily at the Company's offices to smell the bomb-shell in the presence of the Secretary. These pleas did not avail, and the Company was decreed to pay, and having taken the case to an appeal, was again defeated. The case is in a nutshell. The Company resorted to a very old dodge to draw customers, never supposing that anyone would take them at their word, and it must pay for its mistake. On the other hand, the plaintiff cannot claim sympathy, because it is scarcely possible to believe that she was misled by a promise of compensation if the bomb-shell failed to fulfill its promises, and, therefore, she lost nothing by the transaction. —*Med. Press.*

PLUGGING THE NOSTRILS.

The operation of plugging the nostrils for uncontrollable epistaxis is doubtless a very effective method of meeting a difficulty, at the same time, however, it is always a very disagreeable one to the patient. Even the preliminary procedure of passing Bellocq's sound, or failing this, an elastic catheter, is not to be commended as affording particularly pleasant sensations, but the *crescendo* nature, so far as discomfort is concerned, of the whole proceeding is fully illustrated when the plugs, especially the posterior ones, come to be placed in position. Naturally, with a view to obviate such a disagreeable performance, many suggestions have from time to time been made by surgeons, and certain appliances have been vaunted as applicable in cases where otherwise "plugging" is imperatively called for. Unfortunately, however, for suffering humanity whose noses will bleed without stop-

ping, nothing has been discovered which so effectually arrests epistaxis as "plugging," and then, when everything else has been tried to stay the bleeding, and failed, "plugging" is the only thing left to be done. However, it is not without interest to peruse what may be said on this subject by those who are bold enough to propose certain modifications in the details of the operation. The latest to bring under professional notice a new proposal in this regard is M. Phillip, of Brussels, who describes his method as both simple and efficacious for arresting hæmorrhage from the nostrils. He takes a small piece of silk, and placing it round a probe, penholder or sound, thrusts it along the inferior meatus until the posterior nares is reached. The probe is then withdrawn, leaving a sac of silk, into which can be plugged pledgets of cotton-wool until the necessary amount of pressure has been obtained. After the plugging has been completed the ends of the silk which project beyond the nostril are gathered up and tightly tied with a piece of thread. The silk sac may be kept in position as long as may seem necessary. In order to remove it, the pledgets of cotton are taken away piece by piece with forceps. If, however, the hæmorrhage still persists, the sac may be injected with some antiseptic solution, and the plugs replaced. If the bleeding has stopped, the silk may be gently extracted, warm water having previously been injected into the nostril in order to detach the sac from the mucous membrane. In the opinion of the author this plan has several advantages. In the first, place he claims that its application is easy and rapid, and very efficacious, the materials being generally at hand with which it can be carried out. A pocket-handkerchief, for example, will suffice in all cases,—a part of the handkerchief being used to form the sac, while the other part could be made up into plugs. Again, by this method it is impossible to injure either the nasal cavities or the soft palate, and it neither causes coughing nor reflex vomiting. The plug, moreover, remains in position during the whole period of its fixation; and, lastly, no injury is done to the parts when it comes to be removed. With some of these propositions we can agree: it is certainly handy, and easy of application with a handkerchief and a perholder at hand; but whether it would not be highly disagreeable to the patient, more so than the ordinary plan, is a matter which personal experience alone could determine. In one respect, at least, it is superior to the older method, and that is, in securing the safe and complete removal of the blood clots, and in the facility which it affords of washing out the nares with antiseptics and of replugging the sac, should the hæmorrhage not have ceased; at all events, the suggestion is worth noting, and perhaps worthy of a trial. —*Med. Press.*

VOMITING IN CHLOROFORM ANÆSTHESIA.

Passet (*Munch. med. Woch.*, June 7th, 1892) says that the chloroform vapor acting on the mucous membrane of the mouth produces a flow of saliva. This saliva is swallowed, and a certain part of the chloroform is thus conveyed into the stomach. The gastric mucous membrane is in this way irritated, and vomiting is set up. This increased flow of saliva at the beginning of the administration may be seen in animals, especially in cats, as well as in the human subject. For some time after the anæsthesia chloroform is exhaled with the breath, and even this may irritate the mucous membrane of the mouth in the same way, and with the same result. The action of chloroform upon the stomach varies in different individuals. The author adds that the only rational way of preventing the vomiting is to avoid the swallowing of chloroform, and that this may be done more easily than might appear by directing the patient to spit out the abundantly secreted saliva.—*Current Medical Literature.*

ACUTE MERCURIAL POISONING.

In the *Berl. klin. Woch.*, June 20th, 1892, Sackur relates the following case: A girl, aged 20, sprained her wrist. A few days later lymphangitis apparently supervened, for which mercurial ointment was applied and rubbed into some cracks on the hand. An hour after the inunction the patient felt ill, fainted and vomited. On admission the same evening, there was much swelling of the hand and of the arm on its dorsal aspect. An incision was at once made into the brawny and grey colored tissues. The next day, January 16th, there was vomiting with tenesmus and slight albuminuria. Cultivation experiments were negative. On January 17th the vomiting was less frequent, but there was anuria. The stools were blood-stained, and the condition very like that of dysentery. There was no fever. On January 18th, severe hæmatemesis occurred. Diarrhœa with stools of almost pure blood and anuria continued. On January 19th, there was gangrenous gingivitis and glossitis, with moderate salivation. The prostration was great but the mind remained clear. The following day there was a feeling of weight, and then paralysis in the extremities, and the patient died. There were small hæmorrhages and superficial sloughs in the mucous membrane of the lower part of the small intestine and the characteristic appearance of severe dysentery in the large. In the kidneys there were well marked necrotic changes in the epithelium, especially of the convoluted tubes. In the absence of a clear history, the diagnosis from sepsis was at first difficult, but there was no pyrexia or splenic enlargement, and the results of cultivation were negative. The amount of

ointment used was small, but, as has often been pointed out, the broken skin must be taken into account. The author then refers to three recorded cases of fatal mercurial poisoning, in two of which the mercurial application was made for pediculi capitis, and in the third inunction for syphilis. A certain idiosyncrasy must be present. Kaufmann says that nephritis, septicæmia and anæmia are contra-indications to the use of mercury. Marked anæmia and commencing septic processes were present in the case recorded here, and the author would attribute the rapidly fatal issue of the poisoning in this instance to these two conditions, and more especially to the former.—*Current Medical Literature.*

VAGINAL INCISION FOR PELVIC SUPPURATION.

Routier (*Rev. de Chir.*, May, 1892) read a paper at the recent meeting of the Congrès Français de Chirurgie, in which he condemned the too free removal of the uterine appendages so much in vogue in cases of pelvic suppuration. Still more did he object to vaginal hysterectomy for the same affection. This operation, done by *morcellement*, maimed the patient at once, and left her life for hours at the mercy of pressure forceps. Routier has long been accustomed to open Douglas's pouch and to drain through the vagina in cases of collections of pus or blood in the pouch. He finds that the appendages can readily be explored through the incision made in the posterior vaginal fornix. He has often practised this method of exploration, and found that in many cases the simple incision suffices; sometimes abdominal section is needed after all; and lastly, vaginal hysterectomy may prove the more advisable operation. In that case, Routier does not perform *morcellement*, but bisects the uterus by a median antero-posterior incision, removing each half separately. By this method there is little danger of serious hæmorrhage. Each half of the uterus is easily depressed, and with it the corresponding appendages are drawn out without difficulty and safely removed. Routier has succeeded in all the sixteen cases where he has operated in this manner. In three there were multiple fistulæ, and other old intractable lesions.—*Current Medical Literature.*

AN EPIGRAM CONFIRMED.

Dr. W. E. Anthony, of Providence, R. I. writes as follows:

"When I was a medical student, in 1865, I remember hearing Dr. Oliver Wendell Holmes, then professor of Anatomy at Harvard College, say to his class: 'When you begin practice, you will have twenty remedies for one disease, but after twenty years you will have twenty diseases for one remedy.' That prediction seems to be fulfilled in the use of antikamnia, which seems to meet so many indications."

MIDDLESEX HOSPITAL.

EXCISION OF THE COCCYX FOR COCCYGODYNIA.

Under the care of Mr. BLAND SUTTON.

[From notes by Mr. SYDNEY LEE, House Surgeon.

In August, 1892, Mrs. C., æt. 38, was admitted into the hospital suffering from coccygodynia. The patient was confined of her first child in the preceding April. The labor was long, difficult, and necessitated the use of forceps. Since the confinement she had been troubled with a great deal of pain at the lower part of the back, this pain being intensified during defæcation, and especially when rising from the sitting position, being increased too by walking, but not to the same extent as by the movements previously mentioned.

On examining the patient, the tip of the coccyx could be felt projecting forwards towards the rectum; by means of a finger in the bowel the coccyx could be moved backwards and forwards as upon a hinge. These movements provoked great pain.

On August 6th patient was anæsthetized, and an incision two inches long was made vertically over the situation of the coccyx in the mid-dorsal line. The coccyx was freed from its muscular attachments and from the rectum, care being taken not to wound the bowel. When the parts were fully exposed, a fracture was detected between the first and second coccygeal segments; a false joint had formed in such a way that the terminal portion of the coccyx formed a right angle with the sacrum, the tip of the coccyx projecting on to the posterior wall of the rectum. The loose piece was detached by cutting through its fibrous connections, a few vessels were pinched with forceps, the wound closed with thin sutures of waxed silk, simply dressed with lint and cotton wool, and a bandage applied.

13th.—Wound completely healed, suture removed.

14th.—Patient was able to get up, and was free from pain.

26th.—Patient left the hospital convalescent.

Remarks by Mr. BLAND SUTTON.—This is the fifth case in which I have removed the coccyx from women in whom it had been fractured in consequence of prolonged and difficult labor. In each instance the symptoms were almost identical, viz., great pain on defæcation, on rising from the sitting position, and on walking. The pain in these cases is caused by the muscles attached to the coccyx dragging upon it; during defæcation the pull of the sphincter and provoked great pain, and the gluteus maximus on each side drags upon the coccyx when the pa-

tients arise from or assume the sitting posture. The treatment is very simple, so long as the surgeon is content to remove the coccyx at the seat of fracture; in my first two cases I removed the bone beyond with cutting forceps, and the wounds were three weeks in closing. In the three last cases I merely detached the coccyx at the seat of fracture, and in each instance there was primary union. The relief this simple operation affords is remarkable and permanent.
—*Med. Press.*

THE BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, NOVEMBER 24TH.

Dr. W. A. DINGLE, Vice-President, in the Chair

MR. H. REEVES showed a specimen of
SARCOMA OF THE UTERUS.

The patient was a single woman, æt. 52, and complained of a sanious discharge from the vagina, but had no pain. The tumor was pedunculated, attached to the cervix, protruded from the vulva, and also involved the body of the uterus. The microscope revealed it to be a spindle-celled sarcoma.

Remarks were made by Drs. Heywood Smith, C. H. F. Routh, and Bowreman Jessett.

Dr. INGLIS PARSONS read notes of a case of
LARGE FIBRO-MYOMA OF THE UTERUS ABSORBED
BY APOSTOLI'S TREATMENT.

The tumor was diagnosed by Dr. Robert Barnes, who sent to him for treatment, and Dr. Barnes corroborated the disappearance of the tumor. The patient was married, æt. 35, had two stillborn children, menstruation regular but scanty. Dysmenorrhœa for the last two years. She complains of pain in the abdomen and a large swelling. Examination.—The uterus is found to extend to the umbilicus, on the left side is hard and nodular. The sound passes 3½ in. Eight applications of the constant current were made between 8th April and 13th May, 1892, five with the positive pole and three with the negative pole within the uterus, from 50 to 70 milliamperes. On June 20th the tumor was very much smaller, and on July 21st it had entirely disappeared. This patient, in the full tide of sexual vigor, remains a complete woman, instead of being reduced to impotence by removal of the appendages, and she loses the tumor without running the risk of the tremendous mutilation involved by hysterectomy.

CORRECTION.

We regret very much that owing to a typographical error in our April number the excellent valedictory address delivered by Dr. Wilson was credited to Dr. Armstrong.

THE CANADA MEDICAL RECORD.

PUBLISHED MONTHLY.

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MONTREAL, MAY, 1893.

A HINT FOR THE MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

This large and influential society, perhaps the strongest of any in Canada, is obliged to vacate the premises which it has occupied for the last ten years, owing to the demolition of the building. After carefully considering the matter, it has decided to move into much more expensive but also more commodious premises which are being prepared for it, over the office of Dr. Buller. As increased revenue will probably be required to meet expenses, we respectfully suggest a method of raising funds adopted by the College of Physicians of Philadelphia, which includes most of the principal members of the profession, with Dr. Weir Mitchell as president, by which that body received no less than twenty-seven hundred dollars last year, as appears by its published report just received. We take the following words from Dr. Weir Mitchell's annual address:—"When a few years ago the generosity and foresight of a woman induced the Fellows doubtfully to consent to the Nurse Directory, it could hardly have been suspected that not only was this bureau to

be of immense value to the community but that the very existence—the active existence—of this library would depend upon the increasing aid given by the directory in its annual contributions, which, in 1892, reached the sum of \$2,700.00." Further on he says:—"An effort should be made to obtain an endowment, by appealing to the laity." Endorsed as these suggestions are by such a man as Weir Mitchell, we think they might one or both be worthy of the consideration of the Montreal Society, which has done, and is doing, such good work in the cause of humanity.

THE PAN AMERICAN MEDICAL CONGRESS.

On the 5th, 6th, 7th and 8th of September there will assemble at Washington one of the most remarkable gatherings of medical men that this continent has ever seen. Dr. William Pepper, of Philadelphia, is the president, and Dr. Charles A. L. Reed, of Cincinnati, is the secretary general. There will be representatives there, not only from every State in the United States and from every province of Canada, but delegates have been appointed to attend from all the countries of South America. An immense amount of labor has been expended upon its organization, especially by Dr. Reed, with the result that every department of medicine will be fully represented by its own section with its own president and secretary. Already a very large number of papers have been promised, and there is every prospect that the time allotted will be all taken up. Owing to the diverse nationalities of the different delegates, it has been decided to have three official languages, namely, English, French and Spanish, and all papers intended to be read must be sent to the Secretary two months previous to the meeting, in order that an abstract in these three languages may be printed in the official programme. Physicians from any part of the American continent are invited to register their names, but only those residing in the United States will be allowed to pay, the medical profession and the Government of the United States having generously offered to furnish the necessary funds. We shall have occasion to

refer in our next number to the progress which the organizers of this colossal undertaking are making, but in the meantime we trust that a large number of Canadian practitioners will make arrangements to be present.

We call the attention of our readers to the attractive and distinctive Antikamnia advertisement in this number. This firm gladly sends samples free to physicians who will furnish their address.

CORRESPONDENCE.

NANTICOKE, 8th May, 1893.
OPERATORS.

While in Chicago I was fortunate enough to see Dr. Etheridge operate. He undoubtedly is a clever man and a successful and dexterous operator, yet the onlooker cannot help but realize the effort that he puts forth. I saw him perform an abdominal hysterectomy: prognosis good and the result recovery.

Dr. Senn is also a clever operator, but not any better than Roddick, or Bell, and not as nice or as graceful as Dr. Hingston.

Dr. Shepherd is well known in this part of the country by reputation.

In New York I saw Drs. Wyeth and Munde operate at the Mt. Sinai Hospital.

Dr. Wyeth is a very neat operator, extremely cool and collected, operates without any exertion or fussiness, and works very fast—a fact which suddenly dawns upon the observer. He showed me a mass of worms, weighing about 4 oz., which he removed from the small intestine of a man about 25 years of age. The patient was suffering from obstruction. Laparotomy was resorted to, and the above condition found and remedied. I saw the patient convalescent. Dr. Wyeth is himself going to report the case, so I cannot give any details.

Dr. Munde is a very nice operator, thoughtful and cool. I saw a specimen which he exhibited to several bystanders of a uterus weighing perhaps 12 or 15 oz., with a fungus-looking mass projecting from the endometrium. It had been removed per vaginam, the perineum having to be slit to the coccyx in order to allow the mass to pass. The patient left his private hospital in three weeks cured.

The pathologists pronounced the mass in the interior of the uterus the most malignant form of cancer.

BELLEVUE.

Bellevue Hospital interested me very much. The place itself is rather a rickety structure and, I should judge, a very unsanitary place, but they do great work there, and do it well. Their internes serve two years, and it is only in the last six months of their *servitude* that they attain the distinction of *House Surgeon*; he is

then master of the situation in the absence of the visiting surgeon.

I might say that I saw a man there with his *face broken*. His face had been kicked in by a stallion. He received a compound fracture of the inferior maxilla, a fracture of the superior maxilla and the nasal bones. Although somewhat disfigured he is still in the ring. He is a prize fighter.

COLUMBIA SCHOOL.

I was much impressed with the appurtenances of the Columbia School of Medicine—College of Physicians and Surgeons. It is a grand institution, and gives a fine education. Her men as a teaching body are second to none, and the accommodation for the students is superb. The Medical School of Pennsylvania University is excellent, ahead of even Columbia in point of curriculum, but Columbia will outstrip her just as soon as she adopts the four years course.

Jefferson is not what it used to be; though having an excellent teaching staff, and giving a good education, she sorely realizes the loss of the Grosses and Pancoasts, of Barthallow and DaCosta.

I went up before Jefferson to have my certificate endorsed. I was examined in Therapeutics which included Toxicology and Materia Medica, also in Practice of Surgery, Obstetrics and Gynæcology. It was too bad that I did not read Parvin on Obstetrics, as I could then probably have given him the pet theories he desired so much. Prof. Wilson said that Dean Campbell deserves credit for having given me such a good training in practice. He pulled me over every system in the body without any exception. It was my pleasure to call on the professors to be examined, and sometimes had to call 3 or 4 times before I found them home.

Jefferson Medical College is a Stock Company, and no man can obtain a professorship unless he holds stock in the institution.

The professors reap a fat harvest, in my opinion. I was unfortunate in not having had the time to see any men operate in Philadelphia, but the opinion is wide that Prof. Keene is the crack surgeon of the State, that Price is the leading gynæcologist, and that *Pepper was jealous of Osler*.

I have located in Nanticoke, which lies about seven miles south of Wilkesbære. It is perhaps the busiest part of the coal regions. (Nothing else but coal.) Accidents are of daily occurrence, and a man's surgical capacity is at times severely tested.

I find a Dr. Evans here of about 20 or 25 years' experience, a first-rate fellow. He does me the honor of calling me into consultation in any of the severe or not severe smash-ups, and throws a dollar in my way when it is possible. For the other physicians here, I cannot say much, but that they are not pleased to see me is manifest. I don't mind them, however.

I shall in this letter merely report the emergency cases to which I have been called in company with Dr. Evans.

Monday Morning, May 8th.—Dr. Evans hurriedly summoned to a boy who had been kicked in the face by a mule. My assistance was desired, and I therefore had the satisfaction of seeing a most interesting case.

Boy about 17, a mule driver in the mines. He had been carried out of the mine and driven home on a wagon, which must have shaken him up severely. When seen, he was in bed in a deep sleep; some very dirty cloths were about his head which were saturated with blood and *coal dust*. Some little difficulty was experienced in rousing him, but after a shake or two he informed us he was in great pain. Cloths removed, and two large scalp wounds exposed, one cut extending to the bone and ranging from the outer angle of the right orbit in a direction upward, inward and backward, and about three inches in length. The edges of the cut were somewhat ragged, and the surrounding tissues much contused. The bone just internal to the external angular process was bare of periosteum, a vertical linear depression was manifest, and a small spicula of bone could be felt. A slight cut was also present on the right upper eyelid. The eyelid was somewhat puffed, but not more than should be expected; it was moved freely and without any apparent pain. The eye was moved freely without pain, no ecchymosis, and the pupil reacted to light. Some cloth removed from right ear. Drum intact; and no fissure. Considerable coal dust in this wound. Another deep cut was apparent just near and above the right ear, almost horizontal, and exposing most beautifully the temporal muscle. The scalp was almost free between the two wounds, and the whole side of the head was puffy and swollen.

TREATMENT.

Hair was cut away, part washed as thoroughly as possible (some coal dust will always remain), and the cut exposing the temporal brought together by one suture (no drainage). The larger wound over the ext. angular process was brought together by four sutures and iodoform gauze drain inserted. The application of ice was rejected.

Tuesday morning.—Case doing nicely. Temp. 100, pulse 84. Bowels have been thoroughly evacuated, drain removed, healthy looking, but another inserted. Temporal wound united, but looks puffy. Dr. E. separates the margins in case of accident.

Wednesday.—Case reported doing well.

Thursday.—Patient walking about. Slight suppuration about the temporal wound, iodoform gauze drainage inserted. Swelling much reduced, and recovery almost certain. There must be some antiseptic property in coal dust, as wounds here are seldom free from it, yet, if seen early enough, before some old woman begins tinkering,

suppuration is rare. It is a common thing, they tell me, to see a crushed arm or leg just packed with dust, the required flap being literally covered with it, and yet union readily takes place. It is absolutely impossible to wash and scrub it all away.

Friday.—Patient came to drug store to be dressed, looking well.

Dr. Evans asked me to see case.

Miner about 35, married, struck by the products of premature blast. He was running away from it when a large piece of coal struck him from behind in the left popliteal space. He fell forward on his left knee with considerable force, at the same time being struck by coal all over the body with more or less force, a large piece striking him in the left buttock and causing him to stand almost on his head (as per eye witness).

When seen, he was suffering great pain in the knee, but more so in the hip and left buttock which was found contused and swollen. Pelvis and hip joint intact. Some flesh wounds all over the back, arms and legs; none severe enough for treatment. The knee was found without swelling and to crepitate on movement, the proceeding causing great pain; partial flexion with considerable pain, complete flexion impossible. No effusion. Transverse fracture of patella excluded. On taking hold of patella on each side and moving it, a vertical fracture was diagnosed, a slight linear depression being manifest in the vertical axis.

Back splint. Ice. Case doing well.

Wednesday evening.—Case doing nicely, no effusion.

Thursday evening.—Case doing nicely, no effusion.

Monday evening.—Case doing nicely, no effusion. Ice removed.

M. GOLTMAN, M.D.,
Nanticoke, Pa.

BOOK NOTICES.

PICTURES FOR PHYSICIANS' OFFICES AND LIBRARIES.

Edward Jenner, the First Inoculation of Vaccine, May 14, 1796.

Andrew Vesalius, the Anatomist.

Spoonful Every Hour.

The Sick Wife.

Ambrose Paré Demonstrating the Use of Ligatures.

The Young Mother.

The Village Doctor.

Prof. Charcot's Clinic at the "Salpêtrière" Hospital, Before the Operation.

The Rebellious Patient.

Study in Anatomy.

William Harvey Demonstrating the Circulation of the Blood.

The Anatomical Lecture.

The Accident.

Size of each, 19x24 inches. Price each, \$1.00. Catalogues of these pictures will be sent upon application to Messrs. William Wood & Company, 43, 45 and 47 East Tenth Street, New York.

We have seen some of these pictures, and can assure our readers that nothing more appropriate can be found to adorn the walls of a surgeon's office. The price is extremely moderate considering their high quality as works of art.

INTERNATIONAL CLINICS. A quarterly of clinical lectures on Medicine, Neurology, Pediatrics, Surgery, Genito-urinary Surgery, Gynæcology, Ophthalmology, Laryngology, Otology and Dermatology, by Professors and Lecturers in the leading Medical Colleges of the United States, Great Britain and Canada. Edited by John M. Keating, M.D., LL.D., Colorado Springs, Col.; Judson Daland, M.D., Philadelphia; J. Mitchell Bruce, M.D., F.R.C.P. London, England; David W. Finlay, M.D., F.R.C.P. Aberdeen, Scotland. Volume 1, third series, 1893. Philadelphia: J. B. Lippincott Co., 1893. This number contains lectures by J. Bland Sutton, F. Greig Smith, William Pepper, Roswell Park, Arfad Geriter, William Goodell, Michel Peter, M. D. Mann, E. E. Montgomery, W. Hale White and many others of the world's most famous teachers.

LESSONS IN PHYSICAL DIAGNOSIS. By Alfred L. Loomis, M.D., LL.D., Professor of the Practice of Medicine and Pathology in the University of the City of New York. Tenth edition, revised and enlarged. Octavo. Illustrations, some in color. 240 pages, extra muslin; price, \$3.00. New York: William Wood & Company.

No better proof of the value of a work can be suggested than the fact that it has reached its tenth edition. It is so systematically arranged and so clearly written that it is no wonder that it has proved such a favorite with both professors and students. The chapters on the physiological actions of the heart and the lessons on examination of the urine have been entirely rewritten, also a new lesson on clinical microscopy. It is profusely illustrated, and some of the microscopic sections are beautifully colored, and, as usual with the Messrs. Wood's publications, the book is printed and bound in elegant style.

DISEASES OF THE RECTUM AND ANUS: THEIR PATHOLOGY, DIAGNOSIS AND TREATMENT. By Chas. B. Kelsey, A.M., M.D., New York, Professor of Diseases of the Rectum at the New York Post-Graduate Medical School and Hospital; late Professor of Diseases of the Rectum at the Uni-

versity of Vermont, etc. Fourth Edition, revised and enlarged. With two Chromo-Lithographs and one hundred and sixty-two illustrations. Octavo, 496 pages, extra muslin; price, \$4.00. New York: William Wood & Company.

The practical value of this work has been greatly increased by the author having thoroughly revised it before allowing it to come before the profession in a fourth edition. He has incorporated not only those facts which his own very large experience has taught him, but he has also introduced whatever has been discovered by others in the same field. Besides a hundred and sixty-two illustrations, there are chapters such as among others on Abscess, Fistulas, Piles, Prolapse, Non-malignant Growths of the Rectum and Anus, on-malignant Ulceration, Cancer, Artificial Anus, Spasm of the Sphincter, etc.

His points in anatomy and physiology and his general rules regarding examinations, diagnosis and operation are especially good. Dr. Kelsey's large experience as one of the leading specialists of the times lends considerable emphasis to the various recommendations he makes throughout his book.

DISEASES OF CHILDREN. A manual for students and practitioners, by C. ALEXANDER RHODES, M.D., Instructor in Diseases of Children, New York Post-Graduate Medical College. Philadelphia, Lea Brothers & Co.

This little book forms part of "The Students Quiz Series," and contains a vast amount of useful practical information relative to the diagnosis and treatment of disease in childhood. In compiling the work, the author states that many excellent writers on this subject have been consulted, their opinions compared, and of these only such as were regarded as the latest and best have been retained. The purpose of this Compend is simply to present a summary of the diseases of children, and it is trusted that the student and practitioner will fully appreciate that its use is recommended only after a careful reading of the standard books from which its subject matter has been taken.

PSYCHOPATHIA SEXUALIS, with Especial Reference to Contrary Sexual Instinct: a Medico-Legal Study. By Dr. R. von KRAFFT-EBING, Professor of Psychiatry and Neurology, University of Vienna. Authorized translation of the seventh, enlarged and revised German edition. By CHARLES GILBERT CHADDOCK, M.D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis; Fellow of the Chicago Academy of Medicine; Corresponding Member of

the Detroit Academy of Medicine; Associate Member of the American Medico-Psychological Association, etc. In one Royal Octavo volume, 436 pages. Extra Cloth, \$3.00 net; Sheep, \$4.00 net. *Sold only by Subscription.* Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street.

This book shows wonderful erudition on the part of its author, but its contents are too nasty for even medical men to read. There may be cases, and no doubt they are frequent in the utterly depraved capitals of Europe, in which human depravity has reached its lowest ebb, and to understand which some such work as the one before us would find its *raison d'être*. But we have never heard of such cases in this country so far, and we are happy to say that we have never had occasion to consult such a work as this during a fifteen years' practice in the metropolis of Canada.

THE STUDENTS' QUIZ SERIES. Edited by BERN B. GALLAUDET, M.D., Demonstrator of Anatomy and Clinical Lecturer on Surgery, College of Physicians and Surgeons, New York. Volume 8. DISEASES OF THE SKIN, by Charles C. Ransom, M.D., Assistant Dermatologist, Vanderbilt Clinic, New York. Pocket size, 12mo., 192 pages, 28 illustrations. Limp Cloth, \$1.00. Philadelphia, Lea Brothers & Co., 1893.

This little work, although similar to several others on the same subject, is still of a very practical character, and will doubtless prove of service to the student and also to the busy practitioner, as it contains many excellent prescriptions for treating the many and common cutaneous affections. Many illustrations are dispersed throughout the little book, and the letter press is well executed.

THE YEAR-BOOK OF TREATMENT FOR 1893. A Critical Review for Practitioners of Medicine and Surgery. A Series of Contributions by twenty-two writers. In one 12mo. volume of 500 pages. Cloth, \$1.50. Philadelphia, Lea Brothers & Co., 1893.

This is an excellent little work, written well up to date, and is one that every practitioner should have in his library, as he can, by this means, keep himself posted on all the important subjects recently under consideration in the various medical journals. The present edition (the ninth) of this "Year-Book of Treatment" contains two new articles; one is on "Anæsthetics," which is here treated as a separate article instead of being, as hitherto, included in the "General Surgery" portion. There is also a part of the little volume devoted to a branch of medicine which is daily increasing in importance and scientific accuracy, viz., "Public Health and Hygiene." Wood cuts dis-

persed throughout the book add considerably to the value of the work.

BIBLIOTHÈQUE GÉNÉRALE DE PHYSIOLOGIE.—
L'Opium : ses abus; Mangeurs et Fumeurs d'Opium; Morphinomanes, par le Docteur Ernest Martin, ex-médecin-major de l'École Polytechnique et de la Légation de France à Pékin; Lauréat de l'Académie de Médecine. Paris: Société d'Éditions Scientifiques, Place de l'École de Médecine, 4, rue Antoine-Dubois; 1893.

This is a most interesting book of 175 pages, and gives a complete history of the use and abuse of this drug for the last century. It deals with its preparation and consumption in India, China and even in America as well as in Europe. The last chapters are devoted to the latest methods of treating the opium habit. Owing to the author's fluent and easy style, it makes not only profitable but very pleasant reading. We presume that it may be obtained through any of the French book stores in Montreal.

BIBLIOTHÈQUE GÉNÉRALE DE MÉDECINE, Dr. A. A. Cancalon, l'hygiène nouvelle dans la famille, préface du Dr. Dujardin-Beaumetz, membre de l'Académie de Médecine, médecin de l'hôpital Cochin. Prix: 3 francs 50 cent. Paris: Société d'Éditions Scientifiques, 4, Rue Antoine-Dubois; 1892.

Under the form of a series of letters to an elderly lady of the old school, the author gently and clearly breaks down one by one the old ideas of disease, and replaces them by the most modern ones. In the simplest language he explains the most marvellous of the discoveries of modern bacteriology, so that anyone can understand them. For the first time we have ever seen it in print outside of the editorials of this Journal, the author lays down the fermentation of the yeast plant as the type of all microbe diseases, and shows how the growth of this and similar minute vegetables exhausts certain materials from the liquid in which it grows, and throws off excreta which finally put an end to its own life. His letter on heredity is one of the most philosophical we have ever seen. But it is on the subject of the prevention of tuberculosis that the author makes his greatest point, and, no matter how the lady to whom the letters are addressed has been prejudiced by the old ideas on its transmission by heredity, she could hardly read this letter without becoming convinced that the disease is the most infectious one known, and that the only hope of stamping it out lies in the universal knowledge of its transmission by bacilli after birth only. For any of our readers who understand French, a rich scientific and literary treatise is in store when they procure this little work.