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Original Communications.

DISEASE OF THE EAR AS A COMPLICATION IN EPIDEMIC INFLUENZA OR GRIPPE.

By LAURENCE TURNBULL, M.D., PH. G., Philadelphia, Pa., Aural Surgeon to the Jefferson Medical College Hospital, etc.

During the epidemic of influenza or grippe in 1889-90, and 1891, we treated a large number of cases of ear disease both in the hospital and in private practice, and reported the same in the *Virginia Medical Journal*.

In most of the cases there was earache followed by acute otitis media, with a hemorrhagic inflammation of the membrana tympani, passing into perforations of the membrana tympani, the result of a micro-organism migrated from the nasopharynx. In some of the cases there were double perforations with more or less reflex irritation of the brain, and some involvement of the mastoid, followed by tissue abscess situated just beneath the cortical layer. There was pain, chill, and more or less fever, followed by perforation of the membrana tympani; at first a mucous

and, after a time, a discharge of pus. In almost all the cases there was a feeble circulation, irregular pulse and weak heart.

Instead of yielding promptly to the ordinary treatment by sterilized cleansing with a solution of bichloride of soda and glycerine, cocaine solution at night to relieve pain, it had to be followed by carbolic acid with boric acid and aqua pura and careful inflating of the middle ear. Most of the recent cases were protracted for three, four, and even six weeks, and some longer. Then the apophysis of the mastoid became painful, and still more so on pressure. The insufflation of air diminishes the pain for a length of time but leaves the apophysis sensitive to touch, then we resort to the following prescription: Baths for the ear, of alcohol at 90 per cent. containing 20 grammes of pulverised boric acid, or a super-saturated solution which Lowenberg introduced into use for the past twelve years with success in this class of cases.

In the adults there was a large loss of the membrana tympani of a pyriform shape. The nose, throat and Eustachian tubes were inflamed and irritated, requiring spraying with a solution of aqua hydrogentii deoxide

3 per cent. solution with half water, until all secretions were removed, while the pain was relieved by cocaine at night, and then toning the part with liquid albolene and menthol, equal parts, of this using 2 to 5 of the albolene. This treatment had a most happy effect upon the second stage of the rhinitis. Tonics had also to be freely administered. Simple elixir of U. S. P. with phosphate of iron and strychnia, omitting the quinia and substituting salacin. Salacin acts as a mild tonic, reduces temperature, excites perspiration and relieves the catarrh and hyperæmia of the nasopharyngeal mucous membrane. The quinia is apt to increase the tinnitus aurium, which was one of the annoying symptoms.

Ever since 1891, there have been more or less sporadic cases as sequelæ of this distressing malady. In a case which we visited very recently in consultation, the daughter of a physician, a girl three years old, following an attack of grippe both ears discharged pus and both membranes were perforated. She was pale and feeble, and had been in her room for three weeks. The posterior nares were so much affected that a young physician thought from the symptoms she had adenoids and proposed their removal. We found no indications of such growth, but irritation of the mucous membrane extending from the pharynx into the Eustachian tubes. This unfortunately had not been attended to, and the tubes had not been kept free. This can so easily be done and should never be neglected; for by simply passing a short rubber tube of four or five inches, armed with a nozzle, into the nose, and, while the child cries, blow with the mouth piece, this will open the tube, which should be kept open every day after cleansing the nostrils and ears.

The child had no appetite for food and was weak. We therefore ordered essence of beef and eggs soft boiled, as this latter

is the only perfect food we have. The essence of beef acts as an admirable stimulant, using a quarter of a teaspoonful of "Armour's Extract" to a cup of warm water, adding a little salt to this makes a nice drink and few children will refuse it. We also ordered the wash before referred to and the tonic. It is wonderful what large doses of strychnia can be given in these feeble conditions following grippe, so as to tone the heart and improve the appetite and digestion. This child was reported well after two weeks treatment.

CONCLUSIONS.

First. There is a peculiar inflammation of the ear termed influenzal otitis.

Second. It almost always commences with hemorrhagic, dark blue or black bullæ seen in the lower posterior segment of the membrana tympani.

Third. After a time a perforation of the membrana tympani takes place with a discharge of bloody mucó-serous fluid.

Fourth. The pain, which is severe before the perforation, is not entirely relieved by it, and continues assuming more of a neuralgic character. There are subjective noises (tinnitus aurium) such as pounding, hammering and roaring, and if not properly treated by inflation or by Politzer's douche or the catheter, remain after all the inflammation has ceased.

Fifth. Fatal results may follow from meningitis, abscess of the brain, and more frequently sinus phlebitis. Such cases we are called upon to diagnose, being sent to our clinic as abscess of the brain.—*Philadelphia Medical and Surgical Reporter.*

MORPHINISM IN MEDICAL MEN.

Read in the Section on Practice of Medicine at the Forty-fifth Annual Meeting of the American Medical Association, held at San Francisco, June 5-8, 1894. By J. B. MATTISON, M.D., Medical Director Brooklyn Home for Habitue's.

It is a fact—striking though sad—that

more cases of morphinism are met with among medical men than in all other professions combined. It is too true that a very large proportion of cases in general are found in our own fraternity.

In a paper "Opium Addiction among Medical Men," presented in the *Medical Record*, eleven years ago—June 9, 1883, reference was made to the dismissal within a week of a half dozen doctors recovered from the disease, and attention called to the surprising frequency with which it occurs in this particular class. Another decade of professional work exclusively given to the betterment of such patients has brought no decrease in this number; indeed the reverse has quite steadily obtained, so that in a paper, "The Ethics of Opium Habitues," *Medical and Surgical Reporter*, Sept., 1888, in a *résumé* of 300 cases, we noted 118 doctors, and of 125 most recently under my care, 62 were medical men; and the latest reference to my record shows a still larger proportion, being more than 70 per cent.

Again and again I have been asked with surprise, "Why do doctors so often fall victims to morphia, when they more than all others should know the risk attending its use?" Various factors make up the answer to this query. Insurance statistics prove that medical men attain a shorter average lease of life than those of other professions, and the causes that tend to this lessened longevity play a part in the rise of morphinism. It is also true that the wear and tear of their calling provoke a large share of painful non-fatal disorders. Neuralgia, in one or other of its protean forms—especially migraine—which leads the list in the genesis of this toxic neurosis, occurs among physicians with a frequency that may well excite surprise. Add to this the anxious hours, the weary days and wakeful nights which the experience of every busy doctor so often involves, and which, though acting indirectly, still swell the sum of cau-

sative conditions in this chronic toxemia, and little wonder that we have a soil specially rich for a sorrowful harvest if, unhappily, the seed be sown.

It has been asserted that medical men become morphinists through their calling involving frequent handling of morphia, but that statement in my opinion is not true. Erlenmyer shares in this disbelief. Druggists, whose vocation largely exposes them to the same risk—more so in the city than the doctor—do not often become morphinists.

A cause peculiar to the medical man in some cases is that careless curiosity which prompts him—generally a junior—to note the effect of morphia upon himself, and in so doing incur the risk of addiction. Obersteiner refers to such cases. A young physician asserted that while on hospital duty a patient was dismissed who had suffered from carcinoma of the stomach and been treated with morphia injections. Next day he returned, begging for more, as otherwise he must die. This was in 1869, when chronic morphinism and its results were less known than now. As the doctor was inclined to think the patient was romancing, he tried the experiment upon himself to ascertain the effect, became a morphinist and never recovered. Another case was that of a young physician, who, being assistant in a physiological laboratory, thought himself an interesting subject for experiment. More than one doctor whose disease had a like origin has been under my care.

Another cause obtains with physicians to the same extent as in non-medical men, that is the all-too-frequent use of morphia which the modern practice of medicine involves. Of this there is no question. Indeed, it holds more largely with the doctor than with the layman, for the former fully aware of the opiate's power to ease pain, pressed by his duties to get relief with the least possible output of time, and declining to make himself an example of the precepts

tended his patient, as to the value of patience under suffering, that will permit the using of non-opiate remedies, or, if the morphia be demanded, which, at least, will secure its giving at infrequent intervals, or alternating with other anodynes, and so lessen the risk of addiction—lacks a certain inhibitory, so to speak, protection which serves as a shield to the non-professional patient.

Still another genetic factor, and in my opinion the one which outranks all others relative to the frequency of this disease in medical men, is their ignorance or unbelief as to the subtle, seductive, snareful power of morphia. It is to me quite beyond belief that any doctor *fully* realizing how swiftly and how surely the trebly pernicious power of this drug takes one captive will deliberately give himself up to a servitude galling alike to body and mind, and which in most cases ends only with life. Such a suicidal course is opposed to reason, to common sense and to fact.

In expressing this disbelief you will quite likely infer my skepticism as to the common opinion regarding the ethical status of our *confrères* whose ill-starred fortune has brought them such a wretched result. I have long held, and still hold, with steadily growing belief based on nearly twenty-five years study of this disease, and an acquaintance intimate more or less with the history of many hundred cases, that medical men do not become morphinists from an innate propensity to evil, from a merely vicious desire to indulge in the pleasures of the poppy—pleasures which, be it never forgotten, soon and surely give place to its pains—but rather that they are impelled thereto by force of physical conditions that, with the largely prevailing failure to realize the risk incident to incautious morphia using are practically beyond control. This phase of the subject need not detain us, for it has been noted with detail in two papers, "The Ethics of Opium Habitues," *Brooklyn Me-*

dical Journal, August, 1888, and *Medical and Surgical Reporter*, September, 1888.

In reviewing the various causes of morphinism in medical men, the most hopeful feature is the fact that they are largely preventable. In this lies the strongest incentive to presenting this paper, the largest promise that it may do good.

Regarding the cause first cited—the wear and tear of an over-active professional life—we must be specially sanguine who would expect to improve conditions along this line to an extent likely to largely lessen such untoward result; though it cannot be denied that the cares of a medical calling are less exacting than a decade or two ago, and so figure less as a genetic factor in this disease; yet I am bound to confess the outlook much more encouraging should careful and concerted effort be made to make less active the other causes to which we have referred.

Regarding the misdirected zeal of the hapless seeker after self-evidence of the effects of morphia, we can only again warn him—and earnestly—that the experiment is fraught with danger, and the rash act may prove his ruin, for the spark thus applied may set aflame that which will only be extinguished with life. He is a fool who does it, and the truly wise man will curb his spirit of inquisitive research along this line, if only on the score of personal well-being; besides no such self-sacrifice is called for, inasmuch as the peculiar effects of morphia, both as to blessing and bane, are now quite patent to all.

No one who has given the subject special thought will be likely to question an assertion that the use of morphin in the medical practice of to-day is in excess of what an actual need demands. And in direct proportion, more or less, to this excess stands the increase of morphinism. As a factor, applying to cases in general, it outranks all others, though as regards medical men it holds in my opinion second place. Custom

and convenience share in its causation. Custom, because experience has brought a belief in the anodyne-soporific power of morphia, which, while well founded, has not been attended by an equally well grounded belief in its possible power for ill. Convenience, because its promptly pronounced effect favors it as first choice when speedy relief is desired, and especially where, as too often happens with the younger men in the profession, the wish to score such a brilliant result as may prove a stepping stone to rapid professional advancement outweighs a due regard for untoward remote effect, from which appreciation a frequent giving of morphia or any opiate should never, it is well to say, be exempt. This is a truism the force of which should never be forgotten.

Leading all others as a genetic factor in morphinism in medical men, is their failure to realize the insidious power of morphia to speedily get a grip, disburbing and destructive alike to functional well-being of brain and brawn, and in almost every instance one too great to be broken by any self-effort they can command. At this writing I am consulted by a young physician whose case emphasizes this point. Sixteen months ago death left him wifeless and childless. In a specially unhappy moment of his grief he took a dose of morphia. It acted kindly, brought transient relief from his mental pain. A week went by before the second dose was taken, and then—the old story: Quite mistaken as to the poppy power and his own strength to resist—again and again till his capture was quite complete. Commenting on his case he assured me he knew the risk attending morphia taking, and never should have incurred it had he fully realized how direful the result of that risk to him would be.

It is quite beyond credence that a doctor gifted with sound sense would wittingly put his neck in such a noose. Granting this, the only reason for taking such a peri-

ous hazard is, as before asserted, an inadequate appreciation of the morphia's power to enthrall.

Touching this point, enlarged experience confirms an assertion made ten years ago, that "the subtly ensnaring power of morphia is simply incredible to one who has not had personal observation or experience." One of the finest specimens of physical manhood we ever knew, a physician who survived the horrors of Salisbury prison when the death rate averaged 80 per cent., fell a victim after only one month's hypodermic using. Since then, case after case has been under my care in which the initial stage was still shorter. The most notable was an athlete of superb physique, who withstood the rigor of an arctic winter as surgeon to a polar expedition, and then went down before a 'three weeks' daily quarter grain dose of morphia to ease the pain of an injured ankle!

So much for the genesis of this disorder. What the remedy? It is easy to moralize on the weak will—as many, mistakenly, are wont to put it—of our hapless brother living under this blight, but talk about "weak will" as a reason why strong men succumb to morphia—and I make bold to say that the man does not live who under certain conditions can bear up against it—is tittle. Far better is it to face the fact that morphinism finds most often its favorite victims in the noblest profession known, and then recognizing the causes that make this fact, bestir ourselves to such precept and practice as will tend to remove this blot on the scutcheon.

Can this be done? Very largely, yes. In this hopeful belief lies the one redeeming feature of the prevalence of this toxic neurosis in our own guild. Morphinism is on the wane in my opinion, and I am optimistic enough to think the day not distant when it will be largely a thing of the past. But to reach this happy result it becomes the bounden duty of every phy-

sician to inculcate by teaching and by example the paramount importance of the causes we have cited that tend to the rise of this disease.

Two points call for special comment. These are the over use of morphia and the under thought of its danger. Regarding the latter, let me warn with all the weight I can command every doctor who may be dallying with this drug, or who may think its self-taking called for—and this warning holds with special force if the subdermic method be practised—let me warn him that he is inviting disaster by jeopardizing interests vital to his well-being, and let me urge him to pause and to ponder well whether, despite this warning, he dare take such risk. Let him not be blinded by an under estimate of the poppy's power to ensnare. Let him not be deluded by an over-confidence in his own strength to resist; for along this line history has repeated itself with sorrowful frequency, and—as my experience will well attest—on these too treacherous rocks hundreds of promising lives have gone awreck.

I have no wish to pose as an alarmist, but I tell you, gentlemen, that many a doctor who gives himself a daily hypodermic dose of morphia for a fortnight will come perilously close to the danger line—beyond which bondage begins.

Let him not chance it; rather let him, if the opiate demand be imperative, consign its giving to other hands; let it be by mouth; and oftener let it be codeine, which as an anodyne and soporific has not yet had the measure of merit it deserves, and which, as tending to tolerance, is vastly less riskful than morphin. In a paper before the American Medical Association two years ago, "The Prevention of Morphinism" (reprint at command, and by the reading of which I would have every one of you the gainer), attention was called to the value of codeine. Enlarged experience has confirmed the opinion then expressed,

and while I am glad to note the demand for it is steadily increasing, I earnestly urge its still larger use as one of the most promising factors to favor a decline of the morphin disease.

Regarding the over use of morphia, never was there so little excuse for it as now, for never were the means at command to ease pain and bring sleep equal to those of to-day. Modern medicine is richly equipped in this regard, and if these resources be fully availed of, it will go far in a decrease of this ill.

As tending to this, teachers in medical schools should realize that they have opportunity to wield great influence for good, and by word and deed they should improve it. To do so would strike right at the root of this evil, for I truly think the junior members of the profession are the greatest sinners in this regard; and if by timely counsel from their preceptors and college instructors the thousands who year after year begin a medical career can be brought to believe the danger incident to an incautious or needless giving of morphia, and then shape their practice in keeping with that belief, the good work will be largely done.

Slowly yet surely the therapeutic trend is in this direction. More and more the older medical men, impelled by larger wisdom or an experience often unhappy, are quitting the syringe, more and more rarely are they using morphia. The influence of this example must make itself felt on the younger men, and when to this is added the teaching we have commended, the dawn of a better day will not be distant. May that good time coming soon come.—*Journal American Medical Association.*

—In trephining for *Inveterate Headache*, Prof. Keen says, if nothing abnormal be found, the dura should be stitched together and the wound closed, but the button of bone should not be replaced, and occasionally good results will follow.

Society Proceedings.

AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The following is the preliminary programme of the American Electro-Therapeutic Association, which will hold its fourth annual meeting at the New York Academy of Medicine, New York, Sept. 25th, 26th and 27th.

President's address, Dr. W. J. Herdman, Ann Arbor, Mich., Professor of Diseases of the Mind and Nervous System and Electro-Therapeutist in the University of Michigan.

REPORT OF COMMITTEES ON SCIENTIFIC QUESTIONS.

On Standard Coils, Dr. W. J. Morton, New York.

On Standard Meters, Dr. Margaret A. Cleaves, New York.

On Standard Electro-Static or Influence Machines, Dr. W. J. Morton, New York.

On Constant Current Generators and Controllers, Dr. W. J. Herdman, Ann Arbor, Mich.

On Standard Electrodes, Dr. A. Laphorn Smith, Montreal.

Stand and Electrode for Static Electricity, Exhibit of same, Dr. Lucy Hall-Brown, Brooklyn, N.Y.

On Electric Light as a Therapeutic and Diagnostic Agent, Dr. Margaret A. Cleaves, New York.

THE CONSTANT CURRENT.

PHYSICS.—Current Distribution, Mr. W. J. Jenks, M.I.E.E., New York.

Physiological Effects, Prof. H. E. Dolbear, President Tuft's College, Boston, Mass.

THERAPEUTIC USES.—General, Dr. A. D. Rockwell, New York.

Gynæcology,——

The Galvanic Current in Catarrhal Affections of the Uterus, Dr. G. Betton Massey, Philadelphia.

Suites e'loignes du traitement électrique conservateur Gynæcologie. Grossesses consecutives, Dr. Georges Apostoli, Paris.

'Metallic Electrolysis, M. le Docteur Georges Gautier, Paris. Dr. W. J. Morton, New York. Dr. Margaret A. Cleaves, New York. Dr. A. H. Goelet, New York.

Treatment of Urethral Stricture, Report to date, Dr. Robt. Newman, New York.

Diseases of the Eye, Electro-Therapeutics of, Dr. L. A. W. Alleman, Brooklyn, N. Y.

Notes on Goitre and Improvements in Apparatus for treatment of same, Dr. Chas. H. Dickson, Toronto.

Diseases of the Throat, Dr. D. S. Campbell, Detroit, Mich.

The Action of Electricity on the Sympathetic, Dr. A. D. Rockwell, New York.

Diseases of the Nervous System,

The treatment of Neuritis by the Galvanic and Faradic Currents, Dr. Landon Carter Gray, New York.

Electric Sanitation, Prof. John W. Langley, Ph. D., Case School of Science, Cleveland, Ohio.

Physics of the Electric Light in relation to Organized Matter, Prof. John O. Reed, Ph. M., Mich.

Hydro-Electric Methods, Asst. Prof. of Physics, University of Physics, and Appliances, Dr. Margaret A. Cleaves, New York.

Special Hydro-Electric Applications, Dr. Margaret A. Cleaves, New York.

The Hydro-Electric Therapeutics of the Constant Current, Dr. W. S. Hedley, Brighton, England.

INDUCTION CURRENTS.

INTERRUPTED CURRENTS.—Physics, Physiological effects, Dr. W. J. Engelmann, St. Louis, Mo.

THERAPEUTIC USES.—General Faradization, Dr. A. D. Rockwell, New York.

Gynæcological, Dr. A. H. Goelet, New York. Dr. H. E. Hayd, New York. Dr. A. Laphorn Smith, Montreal.

SINUSOIDAL CURRENT.

Physics, Mr. A. E. Kennelly, F.R.A.S., Philadelphia.

Physiological Effects, Dr. W. J. Herdman, Ann Arbor, Mich. Dr. J. H. Kellogg, Battle Creek, Mich.

Therapeutic Uses, Dr. Margaret A. Cleaves, New York. Dr. Wm. Jas. Morton, New York. Dr. J. H. Kellogg, Battle Creek, Mich. Dr. Holford Walker, Toronto. Dr. A. H. Goelet, New York.

Le Courants Alternatifs; leur transformation; leur mesure et leurs application therapeutiques, M. le Docteurs Gautier et Larat, Paris.

On the Sinusoidal Current Method of Regulation the E.M.F. and Resultant Current, Dr. Lucy Hall-Brown, Brooklyn, N.Y.

STATIC AND STATIC INDUCED.

Physics, Prof. Edwin Houston, Ph. D., Philadelphia.

Physiological effects,——

THERAPEUTIQUE USES.—General Therapeutic Uses, Dr. Wm. Jas. Morton, New York.

The Treatment of Chorea, Dr. D. R. Brower, Chicago.

Static induced, Dr. Margaret A. Cleaves, New York.

High Frequency Currents derived from static Machines as per Method d'Arsonval, Dr. J. H. Kellogg, Battle Creek, Mich.

IN MEMORIAM.

Dr. Wm. F. Hutchinson, Providence, R.I. Dr. Robt. Newman, New York. Dr. John Chambers, Indianapolis, Ind. Dr. Plymon S. Hayes, Chicago. Dr. W. J. Herdman, Ann Arbor, Mich.

THE MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, March 23rd, 1894.

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

Dr. David B. Alexander was elected an ordinary member.

Talipes Equino-Varus.—Dr. BELL brought before the Society a man from whom he had removed the greater part of the tarsus for talipes equino-varus. The patient, a farmer, 47 years of age, had not suffered any great inconvenience up to seven years ago, being able to walk fairly well on the outer side of the dorsum of the foot. At that time a large bursa which had developed over the dorsum of the right foot became inflamed and suppurated. Since then sinuses had persisted, and he had not been able to walk with any degree of comfort, and has been frequently under treatment. In January last he came to the Montreal General Hospital for the purpose of having the bursa treated, but as in all probability the disease had extended down to the tarsal articulations, the more radical operation of tarsectomy was advised. After some hesitation he submitted to this operation for the correction of the deformity. At the operation, the astragalus was first removed, then the scaphoid, then a small portion of the head of the os calcis, then the cuboid, and finally to make the correction complete, the tip of the external malleolus and portion of three cuneiform bones were removed. Unfortunately a case of erysipelas had been operated upon on the same table half an hour before, and though every precaution had been taken to disinfect the surroundings, the patient contracted that disease. This prevented splints from being applied in the usual way, so that there is a little more turning in of the foot than usual, but the result is very satisfactory, almost perfect.

Talipes Varus.—Dr. BELL showed a young man, twenty-one years of age, upon whom he had operated for this condition. The patient had been for several years incapacitated for hard work, and lately had been unable to work at all. The left foot was very much worse than the right. Five weeks ago an osteotomy was performed above the ankle joint, turning in the foot and correcting the deformity. The object was to bring the centre of gravity down through the centre of the foot instead of through the inner border.

The difference between the two feet when seen from behind was very well marked.

This operation was introduced by Trendelenberg a few years ago, and has practically superseded all others for serious cases of flat foot, which for one reason or another cannot be treated by appliances. Trendelenberg had

observed that in certain cases of Pott's fracture when care had not been taken to correct the deformity at the time of the accident, a condition resembling flat-foot had resulted. These cases he treated by osteotomy, and subsequently he extended the operation to cases of flat-foot.

Multiple Fracture of the Pelvis and Fracture of the Femur.—Drs. KIRKPATRICK and WILLIAMS presented a mounted specimen which consisted of the pelvis, the last lumbar vertebra and the upper half of the left femur. In the sacrum a fracture extended from the right ala at the auricular surface, which shows numerous splintered fragments, through the five right foramina to the transverse process of the first coccygeal vertebra. On the left side the bone showed many small splinters and incomplete fissures, especially on the anterior surface, extending in the same manner as far as the fourth lateral foramen. The left inferior articular process of the last lumbar vertebra is also fractured. On both sides the superior rami of the pubis showed transverse comminuted fractures. At the junction of the rami of the pubis and ischium on the right side and through the ramus of the ischium on the left are transverse fractures. The left inferior ramus of the pubis also shows an incomplete transverse fissure on its anterior surface. The left femur sustained a transverse comminuted fracture at about the centre of the shaft.

The man from whom the specimen was obtained was employed in excavating earth, when a large mass (400 lbs.) of frozen earth and shale fell on his side and thigh, crushing him to the ground. Four men lifted the man and carried him to a bench. He was conscious, and after recovering from the primary shock was able to sit up; he said that his left leg was broken. Death occurred two hours later from shock or nervous injury, not from hæmorrhage.

Stated Meeting, April 6th, 1894.

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

Compound Depressed Fracture of the Occipital Bone.—Dr. BELL exhibited a boy, aged six, who in August last had fallen into an excavation and had sustained a compound depressed fracture of the left occipital bone. He was seen a few minutes after the accident by Dr. Grant Stewart, who observing that he was rapidly falling into a condition of coma sent for Dr. Bell, who had him taken to the Montreal General Hospital, where he operated. After shaving the head he proceeded to elevate the depressed portions of the bone, the edges being chiselled away, so as to make an elliptical opening, half an inch in the short and one inch in the long diameter. The dura mater was torn and a large clot (about four ounces) was found lying upon the brain, but no

active bleeding was discovered. Up to this time no anæsthetic had been given, but it was found necessary to administer chloroform to finish the operation. The boy made an uninterrupted recovery, and was discharged about six weeks after. Since his return home his mother has noticed deafness in the left ear, some uncertainty about his gait, and incontinence of urine during sleep, which condition did not exist before the examination. No examination of the ears had been made.

Penetrating Bullet Wound of the Brain in the Left Frontal Region.—Dr. BELL also exhibited a little girl, aged 5 years, who, while playing, had become possessed of a loaded twenty-two calibre English revolver, which she had accidentally discharged while resisting the attempts of an elder sister to take it from her. Dr. Hutchison saw her shortly afterwards and sent her soon after to the Montreal General Hospital, where she was given chloroform and the wound exposed. The bullet had penetrated the left frontal region, three-quarters of an inch to the left of the middle line and the same distance above the supra orbital ridge, going completely through the skull, causing a circular depressed fracture of about a quarter of an inch in diameter. The outer fragments of the bone were removed by forceps and the wound enlarged with a chisel. Forceps were then passed in carefully along the track of the bullet, and several spicules of bone removed from a depth of two inches in the brain substance. Blood clot, pieces of broken down brain matter and fresh blood were also removed, when on passing the forceps in, the bullet could be distinctly felt at a distance of two and half inches from the surface; several attempts were made to grasp it, but failed, and considering the region in which it lay, near the anterior cornua of the ventricle, Dr. Bell concluded that the risks involved in persevering in attempts to extract it were too great; therefore, after carefully cleansing the wound, a glass drain was inserted directly into the brain substance and kept in for seventeen days, being shortened on two different occasions. For the first four days the temperature oscillated between 90° and 100°, but afterwards remained normal. The child made an uneventful recovery and was discharged on Feb. 26. From the time she left the hospital she had been absolutely well and is now going to school. Dr. Bell recalled a similar case which he had reported to the Society in the session of 1879-1880; of a man who deliberately shot himself in the temple, and from which the bullet had never been removed. This patient died of phthisis two years later, and at the autopsy the bullet was found lying within half an inch of the falx cerebri.

Dr. PROUDFOOT, having made a cursory examination of the boy, found that the watch

placed against the child's ear could be heard distinctly, whereas if it was removed the slightest distance, the sounds could not be heard at all. Whether this was due to conduction through the bones he could not say, but apparently the nervous portion of the ear was all right. He suggested that the difficulty in hearing might be accounted for by a catarrhal condition of the middle ear brought on by wet dressings, and which would disappear on treatment.

Dr. HUTCHISON had seen the second case, the girl, half an hour after the accident had occurred. The child did not show any symptoms of brain injury. He put her under chloroform, examined the wound, and having found that the bullet had entered the brain, concluded to send her to the hospital. He saw her again after her return from the hospital, and the mother now states that she is even more precocious than before the accident.

Pulmonary Cerebral Abscess.—Drs. ADAMI and FINLEY reported a case as follows:

T. W., aet. 16 years, by occupation a painter, became ill on February 23rd, suffering from a severe cold, which made him take to his bed. He left his bed the next day but was forced to return, the cold having increased in severity, there being a pronounced cough with expectoration and frontal headache. This was followed by pain in the chest, high fever and the expectoration of blood-stained sputum. When he was admitted into the General Hospital upon March 9th, these symptoms had disappeared, and nothing was to be detected in the chest save a few crepitan râles at the base. There was, however, great feebleness, with obstinate constipation. The right pupil was larger than the left, without there being any disease of the fundus. There was no evidence of renal disease. The patient became gradually comatose with coma vigil. The pulse continued unaltered at 84, the respirations were 28 per minute, only increasing at the last moment, the temperature was 100°. The patient died six days after admission.

At the autopsy performed fifteen hours after death, the trachea was found greatly congested with thin blood-stained mucus covering its surface. The bronchi were reddened and affected with bronchitis, the upper lobes of both lungs were œdematous, the lower lobes of both lungs were heavy to the feel and fairly firm, they were greatly congested but at the same time crepitan. At the root of the right lung was a suppurating bronchial gland.

In the heart the one point deserving notice was the condition of the coronary arteries; these, while not definitely atheromatous, were greatly dilated, their walls having undergone fibroid thickening. There were small patches of fatty change in the first part of the aorta, with more distinct atheroma in the lower and dorsal and abdominal aorta.

In the alimentary tract the only markedly abnormal condition was the presence of a suppurative tonsillitis. The liver was somewhat fatty, the pancreas firm and fibroid, with dilated and tortuous artery, the spleen small and fibroid with wrinkled capsule, the kidneys large and long with diminished antero-posterior diameter, distended arteries, finely granular surface, lessened cortex, and with a small cyst upon the surface of the right organ. Beyond these conditions, nothing noticeable was observed. Save for the suppurative tonsillitis and the state of the lungs, the condition of the organs was what is expected to be found associated with the arterio-sclerosis of advancing age.

Coming now to the brain it was noticed that upon removal of a skull cap of abnormal thickness, the left hemisphere seemed to bulge more than the right, and convolutions were more flattened. Upon removal of the organ the vessels at the base were found markedly atheromatous, even to the end of the fissure of Sylvius. Around the roots of the anterior cranial nerves there was a purulent meningitis extending in front to the olfactory bulbs, behind it reached as far back as the line joining the points of egress of the 5th nerves.

Upon opening the lateral ventricle of the left side, it was found to contain a large quantity of fairly clear or semi-transparent greenish muco-pus; in the region of the posterior cornu this extended for several centimetres outwards into the white matter of the brain, forming a channel with smooth walls; this did not extend into the grey matter. The choroid plexus was thickened and oedematous. In the substance of the left hemisphere, opposite to the junction of the temporal and parietal lobes, there was a large cavity in the white matter, containing pus of a like clear mucoid greenish character. Its walls were of reddish-blue colour and were necrotic. The right ventricle contained a large cast of whitish green pus extending over the whole of the mid-region of the ventricle. In the white substance opposite to the ascending frontal convolutions, and upon the level of the junction of the upper and middle frontal lobes was another abscess the size of a hazel nut; this extended quite superficially into the grey matter, less than 1 cm. of wall remaining. It contained similar greenish contents, and had walls undergoing necrosis. There was further a small abscess containing but a few drops of pus in the posterior portion of the right optic thalamus. The pus present in the left ventricle extended down into the third and fourth ventricles. On cutting into the cerebellum the left lobe was found normal; the right lateral lobe was the seat of another abscess with well-defined walls, filled with necrotic material, associated with the same pale greenish pus; this was 5 cm. in the greatest diameter and

about 3 cm. wide, being of oval shape. The pons and medulla were normal.

A few encapsuled diplococci were found in the greenish pus of the cerebral abscesses.

We have recorded this case mainly because of its bearing upon the relationship between lung disease and cerebral abscess. That such relationship frequently exists has long been recognized. Only last year one of us (F.) had a case under observation, presenting many points of similarity with the present, and while we were engaged upon studying the material obtained from this case, our mutual friend, Dr. Williamson, of Manchester, published a short article in the *Medical Chronicle*, bringing together the observations of several observers upon this very subject. Hence it is not inappropriate to call attention here to this case.

Williamson's epitome of the literature of the subject shows that more frequently cerebral abscess develops as an accompaniment of chronic lung trouble, rather than as a sequela of acute. More especially it is in cases of chronic bronchitis and bronchiectasis that the relationship is found. There are, however, several cases in which the abscess formation has followed upon acute pneumonia. In the case mentioned by us the exact conditions which had led to the abscess formation cannot be stated with absolute certainty, although it is safe to infer from the history given that the patient had suffered from croupous pneumonia, and, from the condition of the lung both macro- and microscopically, that this disease had affected the lower lobes on either side. The presence of lanceolate diplococci in the characteristic greenish pus may be urged with some force in favor of this contention. On admission into hospital the condition was one of advanced resolution of the disease, the only active disturbance found at the autopsy being the suppurating gland at the root of the right lung. The presence of this condition of the gland is in itself suggestive of a tendency on the part of the inflammation that had affected the lungs to travel beyond those organs.

It is difficult to offer a satisfactory explanation, or one that will embrace all cases, why there should exist this liability for cerebral abscesses to be associated with disease of the lungs more frequently than, for instance, renal abscesses are found to be thus associated. In our case, it is true, there was extensive atheroma of the cerebral vessels, and the diseased condition of the arteries may have been a predisposing cause; such atheroma, however, is not constantly present.

Remarks.—Dr. JAMES STEWART remarked that although there were plenty of opportunities for examining the case, a diagnosis during life had not been reached. The symptoms were not at all characterized, being simply those of an acute brain lesion causing pressure. He

thought Dr. Adami's explanation was the correct one. Articles have lately appeared in the British Journals pointing out the frequency with which acute central lesions and acute peritonitis were brought about by this organism. At the present time in the Victoria Hospital there is an instance of a suppurating arthritis following pneumonia, and in which the pneumococcus has been found in the joint.

Dr. GUNN had first seen the case referred to by Dr. Stewart in the outdoor department of the Victoria Hospital, and found an area of dullness over the middle of the right lung in front, rather small in proportion to the attendant temperature, which remained in the region of 104° for first 3 days. After entry to hospital a well marked crisis had occurred and temperature remained normal for three days, when he developed a violent chill and showed all the signs of some acute infection or relapse. The following day a swelling developed in the cellular tissue of the left upper arm behind, showing a characteristic erysipelatous appearance, which subsided gradually, and 4 days after all fever had gone, there was another chill and rise of temperature. This time the knee joint on the right side and the left shoulder became very painful, tender and swollen, and on examining the contents a characteristic pus, not decidedly green, but rather of a milky nature, was found. The microscope showed nothing but diplococci with the capsules well marked. Bouillon cultures, however, did not show characteristic diplococcus growth, but rather that of a streptococcus. The examination is not complete—no inoculation having been made.

Dr. GUNN asked if in Dr. Adami's case any other micro-organisms were found and if inoculation had been made.

Dr. MILLS wished to know whether the arteries of the brain in Dr. Adami's case had been examined, and whether steps were taken to exclude emboli or ordinary forms of brain softening in the diagnosis.

Dr. ADAMI stated that abscess of brain with general signs of inflammation in the surrounding tissues were not caused by simple emboli alone.

Gall Stone.—Dr. BELL exhibited a specimen which, though only an ordinary gall stone, had a clinical history of especial interest. On Wednesday last he had been called into the country to operate on a patient supposed to be suffering from appendicitis. She was an unmarried woman, fifty years of age, and although a dyspeptic for many years, which she attributed to the loss of her teeth, she never had a day's real illness in her life. On the previous Friday she began to suffer from pain about the right hypochondrium; her physician saw her on the following Monday and found her suffering from great

pain on the right side of the abdomen. Slight vomiting, normal temperature, and pulse about one hundred. The vomiting persisted all that day and night. Next day vomiting had ceased and morphia was given for the pain, but towards evening of the following day, her temperature rising to 99.5° , her physician grew anxious, and upon making an examination found a resisting mass to the right of the umbilicus and extending up to within an inch of the lower ribs on the right side. Dr. Bell found an area of dullness and resistance extending along the right linea semilunaris upwards to a finger's breadth below the lower border of the ribs and downwards to an inch and a half below the umbilicus. Along the outer border of the mass at the so-called McBurney's point, there was special tenderness, although tenderness existed more or less all over the area of dullness. While concurring in the diagnosis of the appendicitis, Dr. Bell felt that the symptoms might possibly be due to other causes, such as suppurating gall-bladder or some extravasating condition about the stomach, and hesitated to operate in the country. The patient came to Montreal and entered the Royal Victoria Hospital, when on further examination he had almost made up his mind that the case was one of appendicitis. Upon opening the abdomen, however, he found a very much distended gall-bladder, very red and friable walls. Upon making a puncture an ounce of clear fluid escaped, then turbid fluid and lymph, and finally, about an ounce of pus. The stone was found to be impacted in the orifice of the cystic duct, from whence it was dislodged with great difficulty.

This case, though one of ordinary gall-stone, simulating as it did so closely an appendicitis, is of more than passing interest to the surgeon who is now-a-days so often called upon to operate for appendicitis. The stone was an inch in length, three-quarters of an inch in breadth, and half an inch in thickness, being somewhat oval and slightly flattened, and has truncated extremities, one of which was directed into the cystic duct and the other into the cavity of the gall-bladder.

Stated Meeting April 20th, 1894.

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

Dr. Edward J. Kennedy was elected an ordinary member.

Angiosarcoma of the lung.—Dr. JAMES STEWART brought before the Society a young man suffering from a morbid growth of the lung.

Cases of primary sarcoma, affecting either the lung or the pleuræ, are far from common, and the case which we are here about to record possesses, for us at least, a peculiar interest, inasmuch as a positive diagnosis of the condition was made during life. The patient, J.

Van der Wee, a Belgian by birth, aged 35, had been for some years a glass blower. He first felt unwell in the beginning of February, 1894, experiencing constant pain in the left side of the chest. Shortly before admission into the hospital (upon the 7th of April) he suffered from frequent vomiting. Upon admission it was noticed that the upper portion of the left thorax presented very definite bulging, and from the third rib upwards upon the left side there was absolute dullness upon percussion, while auscultation over this area only gave a distant blowing breathing. Vocal fremitus was absent. The dullness and the auscultatory signs were the same both above the clavicle and above and around the upper portion of the scapula behind. While in the hospital pressure symptoms developed in the left arm, the left radial pulse was distinctly weaker than the right, and the difference was well shown in sphygmographic tracings obtained from the two radicals; the surface temperature of the left arm was higher than that of the right, and there was pain extending down the inner side of the left arm.

During the last week of life the patient suffered from excessive vomiting, and was unable to retain any nourishment. Three days before death, which occurred on May the 5th, the patient was noticed to have become suddenly peculiarly anemic, within 24 hours he became delirious, and although a few hours before death his condition seemed to be improved, there was a return of the symptoms and he died with comparative suddenness.

The absence of vocal fremitus, complete dullness on percussion and the pressure symptoms, together with the absence of any marked expectoration, and again the absence of pulsation, led one of us (S.) to a diagnosis of sarcoma. On April the 15th, in order to confirm this diagnosis, an ordinary Pravaz syringe was carefully sterilized, the skin over the region of most considerable bulging, namely, over the second interspace on the left side in front, was washed and rendered aseptic, and in the presence of both of us, Dr. Deeks, the resident physician, passed the needle into the swelling and obtained without great difficulty several drops of fluid. This fluid was in the main composed of blood. In it could be seen small whitish or creamy masses of more solid material. The needle was immediately passed through the side of the cotton-wool plug of a tube of sterilised Glycerine Agar-Agar. A few drops of what remained in the syringe were immediately examined unstained under the microscope, but beyond plentiful red corpuscles nothing could be clearly distinguished; later, one of the small whitish masses removed from the surface of the Agar-Agar, and stained under the cover slip with a dilute solution of methylene blue, showed the presence of large numbers of cells

of a size rather larger than that of ordinary leucocytes, and with nuclei which, instead of being rounded, were of a blunt oval shape. Together with these cells there could occasionally be seen definite thin spindle-shaped cells with nuclei of a more elongated oval or spindle-shaped appearance, but more rarely there were to be recognized larger cells, three or four times the diameter of the cells which formed the main mass. These were filled with minute oily droplets, and had also a more pigmented appearance. It may be added here that the Agar tube placed in the incubator at 37° C. remained completely sterile, save that after several days there developed one small whitish growth which was found non-pathogenic, and which was evidently a contamination from the air.

These cells were from their appearance neither pus cells nor the products nor the accompaniments of any form of chronic inflammation; their appearance entirely tallied with that of a sarcomatous nature, and it was held that here there could be none other than some rapidly-growing oat-shaped cell or oval celled sarcoma present, and in fact the patient was brought before the Montreal Medico-Chirurgical Society upon April the 13th, and the condition was there demonstrated as being one of sarcoma of the lung, or pleura.

At the autopsy performed upon May the 6th, the body was found to be that of a well-developed adult, of medium size, with no signs of emaciation or œdema. There was no difference to be noticed between the two arms, either in circumference or in other respect. The head was not examined. Upon opening the thorax a large soft mass was discovered extending from the very upper extremity of the left side of the thorax down to the level of the sixth rib in the left mammary line. At the level of the second rib the mass extended from the junction of the second rib with its cartilage on the right side across the whole of the left chest. Below this level its edge slanted obliquely towards the left nipple and to the level of the sixth rib as above mentioned. The upper portion of this mass, down to the level of the third rib, was apparently firmly adherent to the costal pleura, so that in order to remove the growth in part this had to be dissected off from the ribs. Below the level of the third rib the wall of the capsule appeared to be thinner; it was of a dark bluish colour and resembled a cyst containing blood. The heart was displaced downwards, and to the left the right lung showed slight adhesion along the fourth rib, behind and forward, as far as the anterior axillary line. Upon removing several inches of the upper ribs upon the left side in order to dissect out the tumor in part it was found that the intercostal humeral nerve passed down from the pleura within the thoracic cavity, that is to say, to the inner side

of the ribs, and that it appeared to be enmeshed or implicated in the capsule of the growth, emerging laterally between the second and third ribs. The first and second ribs of the left side were slightly eroded as far as their cartilages, the third as far as the axillary line, the fourth as far as the angle.

Upon removing the greatly enlarged left lung, the mass upon the upper and anterior surface was found to be peculiarly soft, and so soon as the capsule formed by the costal pleura was cut in two, a large amount of soft semi fluid material of a dark purple color easily passed out through the openings made. As much as 700 cubic centimetres of this material was taken out at the autopsy, and a quantity almost equal in amount was still left within the sac removed at a later period. Save that some portions of this material were of a slightly denser consistency, the whole might have been taken for soft breaking down blood clot.

Upon cutting up the bronchi of the left lung, and passing a probe down the various smaller-sized bronchi of the upper portion of the lung, no communication could be detected between these and the tumour mass, and careful examination showed that this mass lay in the pleural cavity above and anterior to the upper lobe of the left lung. There had evidently been an old chronic pleurisy of some standing, causing adhesion between the upper lobe or the lower boundary of this lobe and the costal pleura, and it was in the sac formed thus between the two layers of the pleura over the upper lobe that a tumour had developed and had extended. The upper lobe itself was greatly compressed, the lower lobe showed compression to a lesser extent; the right lung was smaller than normal. It presented a certain amount of emphysema. At its apex were three or four old calcareous tubercular nodules well encapsuled. The pericardium contained an ounce of slightly blood stained fluid, the heart showed no signs of inflammation, the valves of the heart in general were normal, the abdominal organs presented nothing calling for special remark in this connection. No secondary growths could be recognized by the naked eye in any of the organs.

Upon examination of portions of the softened mass of the tumour, carefully selected from various areas, and hardened either by placing in boiling water for one minute or by Muller's fluid, it was found that the lower edge of the tumour mass was almost entirely, if not quite, pure clotted blood; portions rather denser in their consistency originally, but still equally blood-stained, presented a very interesting condition. They were found to be formed of lobules of sarcomatous tissue, whose cells showed up very well by contrast staining, either with methylene blue and eosin, or with hæmatoxylin and eosin. Running in various directions through these lobules of sarcomatous tissue

were greatly dilated vessels of a purely embryonic type, with walls so delicate that the flattened cells forming them could only here and there be recognized. Immediately around these vessels the sarcoma cells were more densely arranged; these cells were identical in appearance with those that had been removed by the hypodermic needle. They were slightly oval, their nuclei were also oval and stained well, and they were definitely larger than, in fact almost twice as large as, the leucocytes which could be seen here and there lying within the vessels. Away from the vessels the cells became more loosely arranged, and here and there stained badly, inasmuch as lobules were separated from each other by very extensive effusion of blood, and this extravasated blood appeared to be causing the destruction of these outer layer of cells, the extravasation extending in between them.

Careful study of sections taken from various points over the surface of the upper lobe of the left lung led to the conclusion that the tumour had not originated from the visceral pleura; in general the tumour mass could be easily removed from the surfaces of the lung, leaving this relatively smooth and glistening. On the other hand, sections through the costal pleura from the level of the second interspace upwards showed that here the pleura had undergone great fibroid thickening, and that it was infiltrated by masses of sarcoma cells. It would seem evident, therefore, that the tumour had originated, not primarily in connection with the lung, but in connection with the costal pleura.

This condition presents very many points of interest; it confirms the diagnosis that had been made *intra vitam*. The rapid growth of the tumour and the erosion of the upper ribs, indicate that in its development this tumour had pressed upwards, and had thus affected both brachial and nerve supply. The fact that the tumour was extra pulmonary will explain the remarkable absence of direct pulmonary symptoms observable during life; while the character of the growth is fitted to throw light upon the symptoms which immediately preceded death. As we have mentioned, the tumour was of a peculiarly vascular nature; even those parts which were found to stain so well, and which showed most clearly the sarcomatous nature, were, when removed from the body of a consistence scarcely firmer than that of recent blood clot, tearing apart with great ease. In addition to this natural softness of consistency on the part of the tumour, there had evidently been a very great amount of hæmorrhage into the growth, so that the tumour in its lower part was nothing but pure blood clot, and in the rest of the area was a mixture of blood and sarcoma tissue.

The question arises, had these hæmorrhages been continually occurring during several

weeks, or had there been one great and extensive hæmorrhage, which, coupled with the breaking down of the neoplasm, may be looked upon as having been the one immediate cause of death. Undoubtedly there had been a certain amount of hæmorrhage and breaking down of the tumour some weeks before death. This alone is capable of explaining the presence of the occasional large leucocytes, or, if the term may be employed, "Staubzellen," which were found at the time of the exploratory puncture in April, large cells containing the debris of the fatty degeneration of the sarcoma tissue, together with a certain amount of pigment derived from extravasated blood. But we are, notwithstanding this evidence, inclined to believe that shortly before death a most extensive hæmorrhage had occurred, for this alone will account for the sudden onset of extreme anæmia, which was noticed three days before death, and the almost equally sudden low delirium which ensued. That this hæmorrhage was in itself sufficient to account for death we will not say, but it had led to extensive breaking down of the sarcoma tissue, and this hæmorrhage, breaking down of the tissue and absorption of the products formed together, in our opinion, a sufficient cause.

Melanotic Sarcoma of the Foot.—Dr. ARMSTRONG exhibited the specimen which had been removed from the sole of the foot of a woman aged 67. Five years ago she had stepped upon a nail which had pierced the sole. After it was removed the wound healed; one year later it re-opened and discharged pus for some time and again healed. For the past four years it has periodically opened, discharged and again healed up, sometimes remaining closed for a month or two. During this time she had been doing the work of a servant and never had any medical attendance until a month ago when she called upon him. Behind the middle and fourth toe there was a mass about one inch square which resembled an exuberant granulation. Under ether this mass was shelled out with a blunt spoon, it being connected with neither tendon nor periosteum. On examination a lymphatic gland, about the size of an egg, was found below Poupert's ligament, the patient not being aware of its presence. The hæmorrhage after removal was considerable, one or two little vessels spouting.

Dr. Armstrong thought at the time that the condition was malignant, which suspicion was confirmed by Dr. Adami's report. Such cases are instructive, inasmuch as they show that irritation may sometimes set up a growth in situations where otherwise it would not be at all likely to occur, or may change the character of a growth from benign to a malignant type. This principle applies to the breast also, and should impress us with the importance of paying early attention to any lesion which, by con-

tinued irritation, may develop into a malignant character in the later years of life.

Dr. ADAMI stated that the somewhat alveolar arrangement of the cells in portions of this tumour brings up a much debated question as to the nature of these melanotic sarcomas. Are they ordinary sarcomas, or a mixture of sarcoma and carcinoma, or a very malignant form of pure sarcoma? Here, however, the evidence is certainly in favour of a pure sarcomatous nature, the growth originating immediately beneath the Malpighian layer of the epidermis. This tumour differs from many other melanotic tumours by being very well defined, and there being not much evidence of cell growth at its borders, a condition uncommon in primary melanotic growths. It being very superficial may account for it not being attached to the deeper structures. It will be interesting to note if any secondary growth appears in the gland in the groin, for often when the primary growth is of small size there is rapid increase in the secondary form.

A case of Appendicitis.—Dr. ARMSTRONG in exhibiting this specimen, stated that the clinical history was of more than usual interest. The patient, a lady, 46 years of age, a morphinomaniac, gave a history of eight attacks of pain in the lower part of the abdomen. In one of her attacks in November, 1893, she was five or six weeks in bed. Dr. Armstrong saw her for the first time two months ago, when on examination he found in the right side of the pelvis a fairly large mass, hard, painful and tender on pressure. On considering the history of repeated attacks, he advised early removal of the mass. While the patient had this still under consideration, she came and said that she had discharged about a pint of creamy yellow matter from the vagina, then on examination he found that the mass was almost all gone, and therefore came to the conclusion that it had emptied itself in that way. Two weeks ago she complained of abdominal tenderness, and he thinking that she had been taking morphine by mouth was inclined to account for it by the use of that drug. Her temperature, however, rose to 100°, and next day she began to go into a state of collapse. Subsequently the temperature dropped to 95½°, and then quite suddenly returned to normal with an accompanying improvement in the pulse. This latter favourable condition continued for some days, until one morning, when on going to the hospital he found her with a low temperature, small weak pulse, pain and extreme tenderness on pressure. Operation was at once performed. Thinking he had to deal with a tubo-ovarian abscess, he made a median incision, but on going down into the pelvis on the right side he soon reached pus. After working at what he thought was a tube he released it only to find that it was the plexure of the colon which lay to the right

of the uterus, just above the Fallopian tube, which, together with its ovary, was perfectly normal. The colon was filled with water, and found not to be perforated. Then examining the region of the caecum, the blunt and diseased appendix was found. Such a condition in a woman is very misleading, pointing as it did more to a pus tube than to a purulent appendix, especially as her husband was not above suspicion.

Acute Leukæmia.—Dr. STEWART gave the clinical history. The patient, a man, 60 years of age, was admitted into the Royal Victoria Hospital in a condition of high fever and swelling of all the lymphatic glands. These were his chief symptoms during the three weeks prior to his death. There was enlargement of liver and spleen, marked leucocytosis, white to red, varying 1-30 to 1-50. Diagnosis was acute leukæmia, but in this connection it was difficult to explain the high pyrexia, that of leukæmia being very moderate. The patient died from exhaustion, his condition being quite uninfluenced by treatment.

Dr. ADAMI gave the pathological report. The microscopical examination of the liver showed increased amount of fibrous tissue between individual cells pointing to some chronic disturbance. Sections of the pancreas also showed more fibroid tissue than normal. Cultures from the spleen upon agar-agar and beef broth showed the characteristic development of the streptococcus of suppuration. Dr. Adami stated that at the time of the autopsy he had a slight scratch upon his finger, at the site of which small pustules subsequently developed; from these he had made cultures and found very characteristic streptococcus growth. This led to a more thorough examination of all the organs, and enormous numbers of streptococci were found throughout. Emboli formed of the streptococci were found in the marrow of the sternum, in the spleen pulp, filling up the capillaries between the liver cells, in many places in the kidney, in the lymphatic gland, especially those softened glands of the mesentery about the pancreas. They all stained by Gram's method like the ordinary streptococci, and the cultural peculiarities resembled them also. They, however, differed slightly from the ordinary streptococcus of erysipelas and suppuration by growing more freely, the broth in which they grew not being quite so clear as usual, and the size of the chain was rather longer. The inoculation experiments are as yet incomplete.

Dr. BELL asked for some information as to the man's occupation prior to his illness, for it seemed to him from the clinical and pathological report that the case was one of septic infection.

Dr. GEO. BROWN wished to know whether any ear symptoms were present. The case re-

called to his mind one reported in the General Hospital several years ago, in which the only symptom was a septic temperature, and in which a diagnosis of suppurative endocarditis was made. The autopsy, however, revealed suppuration in the lateral sinus.

Dr. GUNN saw the patient when he first came to the hospital, and learned from him that he had been working recently cleaning out the sewers. Another important feature in the case was the nature of the leucocytosis. The increase of the white corpuscles finally reached the proportion of 1 in 37, and consisted solely of an increase of the polynuclear leucocytes, the mononuclear variety not being at all increased. This condition of the blood corresponds with septicæmia. Another very interesting point in the case was the peculiarity of the splenic enlargement, which instead of enlarging downwards extended upwards, its area of dullness reaching behind to the middle of the scapula, and being continuous in front with the heart dullness. At the autopsy this condition was explained by the contraction of the left lung, which accordingly permitted the upward extension of the spleen, as being the direction of least resistance.

Typhoid Fever with Double Pneumonia.—Dr. GEO. A. BROWN reported the case. D. O., age 30, complained of headaches, pain in the back and bones, dyspnoea and cough with expectoration of a rusty character. Family history negative. Patient had scarlet fever and measles in childhood and la grippe four years ago, and since that time has enjoyed good health.

Present illness began about ten days ago (Sept. 25), with chilliness, headache, pain in the back and bones, and slight pain in the abdomen, followed by diarrhoea. About Oct. 1st, he had a slight hacking cough, with expectoration of a frothy character. Thinking that it was only a cold, he tried to battle it off and remained at work until he was compelled to give it up. On Oct. 4th, I saw patient for the first time. He was in a semi-comatose condition and there was marked signs of prostration. Temp. was 105°; Pulse 120; Resp., 40; pupils were contracted and responded to light. I found it very difficult to wake him, and when awake he had difficulty in hearing, and did not understand questions very well.

On examination of the lungs I found sibilant râles all over with rapid and prolonged respiration. At the back in the right inferior scapular region there was dullness, blowing breathing and bronchophony, also some physical signs in inferior axillary region, showing extensive consolidation of the right lower lobe. On left side in left inferior scapular region there was another patch of pneumonia about two inches square.

The abdomen was covered with rose spots.

On palpation it was tense, there was tenderness and gurgling in right iliac fossa, spleen was enlarged; dullness extended from eighth rib almost to the crest of the ilium. Urine normal.

For first seven days (Oct. 5th to 12th) of his illness, patient remained in a prostrated condition. There was present a low muttering delirium, picking of the bed clothes and subsultus tendinum. On eleventh and twelfth of October patient was in a semi-comatose condition all the time, and could not be aroused when nourishment was given him. There was a cyanotic condition of the lips and finger tips. Urine was examined and no albumen found. Oct. 13th, the delirium ceased, the temperature and pulse dropped and there was profuse sweating. In the pneumonic areas there was a few reflex râles.

From Oct. 14th to 21st the physical signs resembled acute miliary tuberculosis, as there were numerous moist râles all over the lungs, more especially in pneumonic portions. There was a hectic flush and profuse sweating towards evening, usually lasting about two hours. There was also frequent coughing, at times followed by muco-purulent expectoration. About Oct. 22nd, physical signs in lungs cleared up; cough ceased, and there were also a few mucous râles in the bases.

The abdominal symptoms at the time were more marked, there was distention and the stools were very fetid.

On Oct. 28th, temp dropped to normal and patient made a good convalescence. Treatment was milk diet, brandy $\frac{5}{vi}$, and Trit. Strychninæ Sulp. gr. 1-30, 4 g.h., and Trit. Hydrarg Subchlor gr. 1-10 2 g.h., while the stools were fetid.

The causation of Inflammation of the Brain.—A comparison of authorities on the subject.—Dr. WESLEY MILLS read the following communication:

Owing to some remarks made at a recent meeting of the Society in regard to the relations between the blood vessels and inflammation of the brain, I have been led to look into the literature of the subject and now submit the following brief references from writers in English.

Fagge in his Principles and Practice of Medicine says: "Now it is well known that an embolism often sets up inflammatory processes in the parts around the vessel in which it becomes lodged."

Bristowe observes in his Theory and Practice of Medicine: "In a large number of cases encephalitis arises from the influence of some irritating mass as a patch of softening."

"Inflammatory changes occur about the softened areas, and when the embolus is derived from an infected focus, as in ulcerative endocarditis, there may be suppuration." According to Flint: "If the embolus is infectious it leads to the formation of an abscess."

Ross (Handbook of Diseases of the Nervous System), believes that, "local disease of the brain, like thrombosis, embolism, etc., often sets up surrounding inflammation of the brain."

Bartholow (Practice of Medicine) remarks that, "more frequently encephalitis has occurred from infective thrombi."

Osler (Practice of Medicine) writing of thrombosis and embolism holds that "inflammatory changes are common in and about the softened [brain] areas. When the embolus is derived from an infected focus, as in ulcerative endocarditis, suppuration may follow."

One of the principles I learned as a student from that great teacher of Medicine the late Dr. R. P. Howard, was, that in any case of fatal brain disease it was a wise precaution to examine the blood vessels of the brain, and, in fact, to look into the circulatory system generally, especially so in cases of softening, inflammation, etc.

From such an examination of the writings of the leading teachers of Medicine of the present and the immediate past as I have been able to make, it appears that such an advice is still sound. While we should welcome any new light that microbic or other processes may throw on disease, I cannot but believe that the old landmarks have not yet all been swept away.

Progress of Science.

INFORMATION FOR CONSUMPTIVES AND THOSE LIVING WITH THEM.

HEALTH DEPARTMENT,
No. 301 Mott Street,
New York, February 13th, 1894.

Consumption is a disease which can be taken from others, and is not simply caused by colds. A cold may make it easier to take the disease. It is usually caused by germs which enter the body with the air breathed. The matter which consumptives cough or spit up contains these germs in great numbers—frequently millions are discharged in a single day. This matter, spit upon the floor, wall or elsewhere, is apt to dry, become pulverized and float in the air as dust. The dust contains the germs, and thus they enter the body with the air breathed. The breath of a consumptive does not contain the germs and will not produce the disease. A well person catches the disease from a consumptive only by in some way taking in the matter coughed up by the consumptive.

Consumption can often be cured if its nature is recognized early and proper means are taken for its treatment. *In a majority of cases it is not a fatal disease.*

It is not dangerous for other persons to live with a consumptive if the matter coughed up by the consumptive is at once destroyed. This matter should not be spit upon the floor, carpet, stove, wall, or street, or anywhere except into a cup kept for that purpose. The cup should contain water, so that the matter may not dry, and should be emptied at least twice a day and carefully washed with hot water. Great care should be taken by a consumptive that his hands, face and clothing do not become soiled with the matter coughed up. If they do become soiled they should be at once washed with hot soap and water. When consumptives are away from home, the matter coughed up may be received on cloths, which should be at once burned on returning home. If handkerchiefs are used (worthless cloths which can be burned are far better) they should be boiled in water by themselves before being washed.

It is better for a consumptive to sleep alone, and his bed-clothing and personal clothing should be boiled and washed separately from the clothing belonging to other people.

Whenever a person is thought to be suffering from consumption, the name and address should be sent at once to the Health Department, on a postal card, with a statement of this fact. A medical inspector from the Health Department will then call and examine the person to see if he has consumption, providing he has no physician, and, if necessary, will give proper directions to prevent others from catching the disease.

Frequently a person suffering from consumption may not only do his usual work without giving the disease to others, but may also get well, if the matter coughed up is properly destroyed.

Rooms that have been occupied by consumptives should be thoroughly cleaned, scrubbed, whitewashed, painted or papered before they are again occupied. Carpets, rugs, bedding, etc., from rooms which have been occupied by consumptives, should be disinfected. The Health Department should be notified, when they will be sent for, disinfected and returned to the owner free of charge, or, if he so desires, they will be destroyed.

By order of the Board of Health,

CHARLES G. WILSON, *President.*
EMMONS CLARK, *Secretary.*

CIRCULAR OF INFORMATION TO PHYSICIANS REGARDING THE MEASURES ADOPTED BY THE BOARD OF HEALTH FOR THE PREVENTION OF TUBERCULOSIS IN THE CITY OF NEW YORK.

HEALTH DEPARTMENT,

No. 301 Mott Street,

New York, February 13, 1894.

The communicability of pulmonary tubercu-

losis has been so thoroughly established, and is now so generally recognized by the medical profession throughout the world, that the Board of Health of New York City has determined that the time has arrived when active steps should be taken, looking towards its prevention in this city. The Board has therefore resolved to adopt the following preliminary measures:

First—The Department will hereafter register the name, address, sex and age of every person suffering from tuberculosis in this city, so far as such information can be obtained, and respectfully requests that hereafter all physicians forward such information on the postal cards ordinarily employed for reporting cases of contagious diseases. This information will be solely for the use of the Department, and in no case will visits be made to such persons by the inspectors of the Department, nor will the Department assume any sanitary surveillance of such patients, unless the person resides in a tenement-house, boarding-house or hotel, or unless the attending physician requests that an inspection of the premises be made; and in no case where the person resides in a tenement-house, boarding-house or hotel, will any action be taken if the physician requests that no visits be made by inspectors, and is willing himself to deliver circulars of information, or furnish such equivalent information as is required to prevent the communication of the disease to others.

Second—Where the Department obtains knowledge of the existence of cases of pulmonary consumption residing in tenement-houses, boarding-houses or hotels (unless the case has been reported by a physician, and he requests that no visits be made), inspectors will visit the premises and family, will leave circulars of information, and instruct the person suffering from consumption and the family as to the measures which should be taken to guard against the spread of the disease, and, if it is considered necessary, will make such recommendations for the cleansing or renovation of the apartment as may be required to render it free from infectious matter.

Third—In all cases where it comes to the knowledge of the Department that premises which have been occupied by a consumptive have been vacated by death or removal, an inspector will visit the premises and direct the removal of infected articles, such as carpets, rugs, bedding etc., for disinfection, and will make such written recommendations to the Board as to the cleansing and renovation of the apartment as may be required. An order embodying these recommendations will then be issued to the owner of the premises, and compliance with this order will be enforced. No other persons than those there residing at the time will be allowed to occupy such apartments until the

order of the Board has been complied with. Infected articles, such as carpets, rugs, etc., will be removed by the Department, disinfected and returned without charge to the owner.

Fourth—For the prevention and treatment of pulmonary tuberculosis, it becomes of vital importance that a positive diagnosis shall be made at the earliest possible moment, and that the value of bacteriological examinations of the sputa for this purpose may be at the service of physicians in all cases not under treatment in hospitals, the Department is prepared to make such bacteriological examinations for diagnosis, if samples of the sputa, freshly discharged, are furnished in clean, wide necked, stoppered bottles, accompanied by the name, age, sex and address of the patient, duration of the disease, and the name and address of the attending physician. Bottles for collecting such sputa, with blank forms to be filled in, can be obtained at any of the drug-stores now used as stations for the distribution and collection of serum tubes for diphtheria cultures. After the sputum has been obtained; if the bottle, with the accompanying slip filled out, is left at any one of these stations, it will be collected by the Department, examined microscopically, and a report of the examination forwarded to the attending physician free of charge.

Fifth—The authorities of all public institutions, such as hospitals, dispensaries, asylums, prisons, homes, etc., will be required to furnish to the Department the name, sex, age, occupation and last address of every consumptive coming under observation within seven days of such time.

It is the earnest wish of the Board of Health that all practicing physicians in this city cooperate with the Board in an earnest and determined effort to restrict the ravages of the most prevalent and formidable disease with which we have to deal.

By order of the Board of Health,

CHARLES G. WILSON, *President*.
EMMONS CLARK, *Secretary*.

WHEN TO OPERATE FOR SQUINT.

E. JACKSON (*International Medical Magazine*, February, 1894), in a careful consideration of the question of operations for strabismus, makes the following points:

No operation should be done so long as other methods of treatment offer any probable chance of relief. The slow development of co-ordinating power in some children, and the possibilities of change by future development, should prevent early operative interference; and as a rule, therefore, operation should not be undertaken before the age of five or six years, and at that age complete correction by operation should rarely be attempted. At puberty, complete correction of the squint by operation should be

undertaken where it has been incompletely corrected or is of low degree. In adult life, the existing indications govern the operation. In cases of squint due to ametropia, the latter should be corrected before operation is attempted.

THE TREATMENT OF PULMONARY TUBERCULOSIS WITH PROFESSOR KOCH'S TUBERCULIN.

KARL VON RUCK (*International Medical Magazine*, February, 1894) refers to his earlier article, in which he reported (*Therapeutic Gazette*, June 15, 1891) twenty-five cases of pulmonary tuberculosis treated with Koch's tuberculin. He then gives the present condition of these patients.

Class A, of five cases reported, all recovered, or one hundred per cent. of recoveries.

Class B, of seven cases reported, six made a final recovery, and one improved, making eighty-six per cent. of recoveries.

Class C, thirteen cases were reported, six of which have improved, while seven have died.

After giving some precautions in regard to the selection of patients and making observations while they are under treatment, he gives his method of administration of tuberculin as follows:

"Beginning with one-twentieth of a milligramme as a trial dose, to which I have never seen a response, the next dose is one-tenth of a milligramme, and the increase is thereafter one-tenth until one whole milligramme is reached; then I increase one-fifth of a milligramme until two milligrammes are reached; next, one-half milligramme up to ten; from ten to twenty milligrammes I increase two and one-half milligrammes, and thereafter five milligrammes at a time."

He has treated one hundred patients with between six and seven thousand injections, and he therefore concludes that tuberculin is no longer on trial as an experiment, but, on the contrary, its effects are as reliable and as uniform as one could expect them to be under the large variety of individual conditions, such as constitution, stage of the disease, parts involved, or complications present.

A CASE OF MULTIPLE OSTEO-ECCHONDROMA.

WHITTAKER, of Cincinnati (*International Medical Magazine*, February), also reports, in detail, an interesting case of multiple osteo-ecchondroma.

A farmer, aged forty, received a shock and a stroke of lightning when six years old. Nine months afterward, the middle joint of the right index finger began to enlarge, and gradually all of the joints of both hands, except the thumb and little finger of the left, became involved,

so that the fingers now have the appearance of medium-sized nodulated potatoes. The largest nodule is on the index finger of the right hand with a circumference of eleven inches. The right upper and lower extremities are much shortened, owing to the development of bony masses, which deform the bones. On the right external malleolus is an enlargement about the size of a lemon. The toes of the right foot are involved in the same manner as the hands, the left foot being nearly normal. The article is well illustrated, and a careful review of the literature of this condition follows.

A CASE OF ACROMEGALY.

MOYER details a case of this rare disease, acromegaly, in a man twenty-four years of age, which began at the age of seventeen by rapid growth of the whole body, especially of the hands. At twenty the eyebrows began to enlarge. Subsequently to an attack of influenza he had had pain in the head, the hands and fingers. The present condition shows enlargement of the frontal sinuses and of the soft tissues covering them; the nose is large, the lower jaw wide, and the lips thick. The circumference of the head is 24.5 inches. The spade-like, symmetrical hands measure 9 inches in length and 4.5 inches across the palm, and are covered with coarse, thick skin. The mental capacity has failed. Examination of eyes showed a high degree of hyperopia of both eyes, squint of right eye, with some optic atrophy and amblyopia of the left.—*International Medical Magazine*, February, 1894.

A CASE OF RHINOPHYMA.

A. H. OHMANN-DUMESNIL (*International Medical Magazine*, February, 1894) reports a case of rhinophyma operated upon with remarkable success.

The patient, a man about seventy-two years of age, had an enormous acne rosacea. The mass consisted of a central and two lateral lobes, and weighed, on removal, nearly two pounds. The tumor covered the upper lip and encroached upon the lower, causing stenosis of the nostrils and affecting speech and respiration. The skin was thickened and the sebaceous ducts patulous.

Operation for removal of the entire mass was performed in the following manner: Each lobe was removed, leaving a small flap of integument on each lower portion, which brought the line of stitches near the sulcus of the ala on each lateral portion, and directly across the nose on the middle lobe. The wound healed by first intention, and only a very slight deformity remained.

Microscopical examination of sections of a lateral lobe showed the stratum corneum and

stratum mucosum normal, or nearly so, the cellular structure marked, the pigmentary layer very prominent; the corium was lost in fibrous tissue; the blood vessels large with hypertrophied walls. The sebaceous glands varied greatly in number in different sections. They contained sebaceous material, and the ducts opened freely upon the surface of the skin. Cystic bodies filled with fatty material were found. The coil glands were normal, their ducts penetrated the entire hypertrophied mass. The subcutaneous fat was about normal. Isolated fat-cells and irregular masses were found in the fibrous tissue, which he thinks were derived from sebum or from a *columna adiposa*, as described by Warren. Two half-tones show the patient both before and after the removal of the tumor.

AN IMPROVED CELL OF GLASS AND CELLULOID FOR THE PRESERVATION AND EXHIBITION OF MACROSCOPIC EYE-SPECIMENS.

C. A. OLIVER (*International Medical Magazine*, February, 1894) describes an airtight cell for the preservation of macroscopic eye-specimens. It is made of two parts, the upper one being of glass in the shape of a Petry or chemical crystallizing dish, which sets into a celluloid base by means of a deep circular groove. The glass is filled with the preservative fluid (gelatine), the specimen introduced, and the base applied, and the whole inverted, the raised bottom will press out all air-bubbles, and the glass can then be cemented to the base. A single hand magnifying-glass of any amplification or the ordinary dissecting microscope is then used for examination of the specimen.

SURGERY OF THE TRIFACIAL NERVE.

H. REINEKING, M.D. (*International Medical Magazine*, February, 1894), after briefly reviewing the literature of this subject, and considering some of the important modifications as made by Carnochen, Thiersch, Heuter, Koenig, Leucke and Mussbaum, refers more especially to the removal of the Gasserian ganglion and to intercranial neurectomy as practised in the last three years by Horsley, Andrews, Rose, Hartley, and others.

He then reports a case, a summary of which is as follows:

J. B. M., a farmer sixty-three years of age, gives a history of pain in the right supra orbital region for ten years, and in the right infra-orbital and right occipital regions for five or six years. Within the last two or three years the pain has extended to the upper molar teeth. It generally starts in the frontal region, and is never first in the occipital. It is accompanied by twitching of the muscles of the parts affected. The case is one of very severe chronic intract-

able neuralgia of some of the branches of the ophthalmic and superior maxillary divisions of the trifacial nerve, accompanied by less severe but equally obstinate neuralgia in the region of the great occipital nerve.

Neurectomy of the frontal and infra-orbital nerves was decided upon, and the following operation was made: the supra-orbital nerve was exposed at its point of emergence from the supra-orbital foramen, liberated by chiselling away a small portion of the ridge, and separated as far back in the orbit as possible. By traction, twisting and a little dissection of the nerves, nearly all of the orbital portion and its branches were removed. The infra-orbital was exposed by removal of the roof of the infra-orbital canal, and grasped and twisted off in the same manner as before. A small opening into the antrum of Highmore was accidentally made, and was drained for three or four days. The wound healed by first intention, and all pain disappeared in about three days.

The points in the treatment on which the writer would lay special stress are: 1. Thorough following up, extracting, and dissecting out of the peripheral, muscular and cutaneous branches; 2. slow torsion, and gentle stretching of the central stump until it gives way.

CLASS ROOM NOTES.

—Creasote, Prof. Hare says, will often prove valuable in *Bronchitis* of a chronic type.

—Prof. Hare says that ergot will sometimes prove a valuable drug in cases of *Diabetes Insipidus*.

—Vomiting is a common symptom, Prof. Wilson says, at the onset of *pneumonia in children*.

—Prof. Wilson says, chills, very rarely mark the onset of an attack of *Bronchial Pneumonia*.

—Prof. Hare says iodine and all its preparations are contra-indicated in cases of *Parenchymatic Nephritis*.

—Colocynth is the best drug, according to Prof. Hare, to administer in cases of *Constipation* accompanying gout.

—Prof. Hare says the best agent that can be employed in cases of *Rheumatoid Arthritis* is arsenic in large doses.

—As a rule, the first symptom that presents itself in a case of *Laryngeal Diphtheria*, Prof. Wilson says, is hoarseness.

—In *Septicemia* following infection from the uterus, we generally have a greater or lesser tendency to diarrhoea.

—*Human Vaccine Lymph*, Prof. Wilson says, produces a less troublesome sore than that caused by bovine lymph.

—Prof. Wilson does not think that ether children or aged persons should be bled or leeches in cases of *Pneumonia*.

—Ergot in combination with the bromide of potassium, Prof. Hare says, is often very serviceable in cases of *Retinitis*.

—*Chloroform*, Prof. Hare says, should never be given a patient in the erect posture; ether may be so administered.

—Prof. Parvin says that chloral injected into the rectum has been found useful in the treatment of cases of *Vomiting during Pregnancy*.

—*Rheumatism*, Prof. Wilson says, is of very rare occurrence either in very cold or hot climates. It is most frequent in temperate climates.

—*Amyl Nitrite*, Prof. Hare says, will be found to be useless in relieving pain unless the latter be due to spasm or to angina pectoris.

—Prof. Keen says that the most suitable time to operate on a child for *Harelip* is between the sixth week and the third month after birth.

—Prof. Parvin says in cases of *Puerperal Infection*, alcohol internally, in large amounts, will be found to be the most valuable of internal remedies.

—Prof. Brinton says *Pneumonia and Pleurisy* may be produced, in fracture of the ribs, by rubbing the fragments against the pleura and lungs.

—Prof. Parvin thinks that intermitting contractions and sensitiveness of the uterus are both unreliable signs in the diagnosis of *Inversion of the Uterus*.

—Prof. Wilson thinks that during the early part of an attack of one of the *Infectious Diseases*, the diet of the patient should be light, and he should not be over-fed.

—Prof. Parvin says in about one-third of all cases a chill occurs during *labor* or soon thereafter. This chill is of no significance, and is not attended with any change in the character of the pulse or temperature.

—Prof. Brinton says *Emphysema* may develop in a case of fracture of the ribs, due to the fractured rib penetrating the pleura and the lungs. As a rule, nothing need be done for the emphysema, as it will generally disappear of its own accord.

—Prof. Keen says in operating in a case of *Hemorrhage*, due to injury of the head, the question on which side to begin should not be decided by the site of the injury, but by the localizing nervous symptoms which manifest themselves.

—Prof. Keen says in *Acute Encephalitis* alcohol in any form is to be avoided in the early stages; but during the latter stages, especially when exhaustion and a typhoid condition develop, it may often be administered with advantage.

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MONTREAL, AUGUST, 1894.

POCKET BOROUGHS IN HOSPITALS.

Medicine has ever held high rank amongst the liberal professions, and none, perhaps, is better entitled to it, whether we base its claims on the devotion to duty shown by its members, or the broadness and liberality which almost invariably characterize their views. It is even one of the unwritten laws of the body, that all discoveries, even those which may have cost long years of investigation and toil, shall be placed, without delay, at the disposal of the Faculty. When a brother errs, it is our duty to counsel him; when he is traduced, to defend him, and, when in trouble, to help him. In these, and in countless other ways, have the members of our profession, in their relation with each other and with the world generally, shown a generosity of spirit and a degree of single-mindedness which challenge unqualified admiration. Nevertheless there are not wanting instances to prove that self-interest is beginning to assert itself with marked prominence, and would appear, at times, to predominate over all other considerations. This was forcibly illustrated, some short time since, when certain physicians connected with the Protestant General Hospital in Ottawa passed a resolution that those who were attended by the hospital staff, and those alone, should receive the benefits of the nursing and diet provided by the institution, and that all other patients should be denied these comforts. This naturally drew

forth an indignant protest from those members of the profession who were not of the hospital staff, and so fully was this endorsed by the public generally, that the staff rescinded their resolution; but, rather than allow patients of outside practitioners to engage private rooms, they decided to close the privilege against all.

A similar spirit of exclusion, for such it certainly is, manifests itself in connection with the conduct of two of the great public hospitals of this city—the Montreal General and the Royal Victoria. The first of these was built and is supported by subscriptions not only from the rich, but from the poor, and is regarded as par excellence the Public Hospital of Montreal. It seems incredible, yet it is a fact, that should even one of those subscribers become an inmate of this institution, he would not be permitted to have his family physician in attendance unless the said physician should happen to be a member of the staff—a hardship, it must be admitted, which affects equally patient and physician. Let us suppose the case of a gentleman who is found in a state of unconsciousness on the street. He is transferred to an ambulance, and on “coming to” finds himself in a private ward of this General Hospital. He asks that his family physician may be summoned, but, should that gentleman not be one of the staff, the request is refused. Should he even present himself at the bedside of his friend, he will not be permitted to treat or even advise one who is now, *volens volens*, the patient of this particular doctor on duty for the time, who will studiously exclude every possibility of outside interference. Should the patient ask to be removed, his family or friends will be at once warned of the danger attending any such change, and he is thus persuaded, forced would be the better term, to accept the services of one who is probably a stranger to him, at the risk of severing, it may be, a life-long connection, and with it all the moral advantages begotten of years of mutual confidence and esteem.

That the Royal Victoria, the pride of its founders, should lay itself open to charges of a similar nature, will not only astonish but pain great numbers of our citizens, who had believed that not even a suspicion of illiberality should be allowed to creep into its management. Added to the fact that this great institution is as thoroughly equipped as any hospital in America

or elsewhere, it has also a large number of private rooms, yet, following the selfish and ungenerous example of the "Montreal," these are closed to all patients other than those of the favored half-dozen who constitute its staff, and in so far, therefore, as this portion of the Royal Victoria is concerned, it cannot be said that either the general public or the members of the medical profession are free to enjoy what it has believed, and what they are given to understand, would be open to all on equal grounds. Distinguished physicians who have visited this city have expressed surprise that such a state of things should be permitted to continue in the conduct of these two institutions, more especially as it contrasts so unfavorably with that which obtains in the management of the Hotel Dieu, the Notre Dame and the Western Hospitals. The Hotel Dieu, the oldest and largest hospital in Canada, opens its private rooms, at a minimum cost, to the patients of any qualified physician, regardless of creed or country, although, considering the fact that it receives no contributions from the public, it might claim and exercise the rights of a "pocket borough" with more reason and justice than those which exercise them without even the right to claim them.

Notre Dame acts with equal generosity towards the profession, and any one of its members is privileged to place his patient in the private wards. Some narrow-minded persons may advance the argument that those two institutions are under French control, and that the French are generally more polite and generous than the English. While we should repudiate this proposition on general grounds, we meet it in this particular case by the well-known fact that the Western Hospital, which is an English institution, has opened its private wards to the profession generally from the earliest days of its existence, and keeps them open to the present day, while its management in every other respect is characterized by the fullest measure of liberality. In thus drawing attention to what we consider a grievance which should be condemned by all fair-minded persons, we are influenced solely by a sense of what we owe not only to those whose particular interests it is our especial duty to protect and advance, but to our fellow citizens generally, and to all who desire to see the public institutions of the country honestly, impartially and intelligently

governed. Let us hope our remarks will be accepted in the spirit in which they are offered, and that what is now a stain on the escutcheon of our noble profession will not be permitted to remain.

A HOSPITAL FOR CONSUMPTIVES.

We are pleased to learn from the June number of our excellent contemporary, the *Dominion Medical Monthly*, that Toronto is about to have a hospital for consumptives, a generous citizen of that town, Mr. W. J. Gage, having offered \$25,000 for that purpose. The CANADA MEDICAL RECORD has again and again insisted upon the contagiousness of the disease as well as its large death rate, and we have continually urged the necessity for special hospitals for sufferers from this disease.

It is probably owing to the work of isolation carried out by the consumptive hospitals in England that the death rate there from this disease has gradually decreased in recent years. In the meantime Dr. Trudeau of Saranac Lake in the Adirondack Mountains is doing good service by establishing a Sanitarium which should be more heartily encouraged than it is. But we have always taken the stand that, as the disease is a national scourge, Canada as a nation should take steps to stamp it out.

PERSONALS.

Dr. N. W. Senn is engaged on a new work on tumors, and in order to obtain quiet and inspiration is spending July and August among the cool breezes in the Canadian Maritime Provinces. He intends visiting Montreal on his way home.

Dr. Hingston, we see by the Toronto Medical Journals, has been a very welcome visitor at the recent successful meeting of the Ontario Medical Association, where he was invited to read a paper. Both the latter and also his speech at the entertainment following are said to have been, the one learned and the other particularly witty.

Dr. Major is spending the summer in England and the continent, while Dr. Hamilton is occupying his residence and office in Union Avenue.

Dr. Proudfoot was so fortunate as to win the election at the Montreal General Hospital to the position of Oculist and Aurist, rendered vacant by Dr. Buller's removal to the Royal Victoria. Dr. Proudfoot still retains his position as Oculist and Aurist to the Montreal Dispensary, where he has served so faithfully for so many years.

Dr. Hamilton has been elected Laryngologist to the Montreal Dispensary, where he attends on Tuesdays and Thursdays at four o'clock.

Dr. Laphorn Smith has returned to the city after a five weeks vacation to the Pacific Coast, where he attended the Gynecological Section of the American Medical Association, of which he has been elected a member. He was one of a party of thirty physicians who were the guests of the President of the Association, Dr. Donald McLean of Detroit.

Dr. F. W. Campbell has returned from his annual vacation at the salmon fishing in New Brunswick, the doctor, as every one knows, being a past master of the art of landing the king of fish. Dr. Campbell is building one of the handsomest residences on Sherbrooke street at the corner of Crescent street, of red and white sandstone, which will be ready for occupation this winter. He will be missed from the classical regions about Beaver Hall and Phillips Square.

Dr. McPhail has been combining business with pleasure by going on a wedding tour to visit the principal hospital cities in Europe. He has recently returned after an absence of several months with increased knowledge and improved health.

Dr. Wilson, 2436 St Catherine street, Montreal, is the latest and most welcome addition to the corps of Montreal specialists. After having spent several years in New York under Dr. Phelps, the leading authority on this branch in America, Dr. Wilson has returned to Montreal, where there has long been a great need of an Orthopedic Surgeon. Dr. Wilson is working up a nice clinic at the Metropolitan Dispensary.

BOOK NOTICES.

TUMORS, INNOCENT AND MALIGNANT. Their clinical features and appropriate treatment.

By J. Bland Sutton, F.R.C.S., Assistant Surgeon to Middlessex Hospital, London.

In one octavo volume of 526 pages with 250 engravings and 9 plates. Cloth \$4.50.

Lea Bros. & Co., publishers, Philadelphia.

In his introductory remarks the author states that having been convinced eight years ago of the great increase in diagnostic power that results from the combination of pathologic and clinical knowledge, he began to collect materials from man and the animals in order to make himself acquainted with the histological peculiarities of tumors. He first took up the subject of cysts; then cancer, which he employs in a sense equivalent to malignant adenoma, the species being determined by the gland in which the cancer arises. He thinks that the terms scirrhous, colloid and medullary or encephaloid have dominated the minds of surgeons and hindered progress long enough. As in his

classical work on diseases of the ovaries and tubes he makes frequent use of his great knowledge of comparative pathology. He groups all tumors into four classes. 1. Connective tissue tumors; 2. Epithelial tumors; 3. Dermoids; 4. Cysts. Each group contains several genera; each genus has one or more species; of each species there may be one or more varieties.

Mr. Sutton then proceeds to deal with each variety of tumor, introducing such a knowledge of the pathology not only of man but also of animals as is very rare. He draws freely on the wealth of specimens in the Royal College of Surgeons, bringing before our notice many strange and interesting facts which have hitherto been buried there. Pathology is generally considered rather a dry subject, but this certainly cannot be said of Mr. Sutton's book, for he presents even the driest facts in such a delightfully interesting manner that one is loth to lay it down when once started to peruse it. It is if possible made still more interesting by the very large number of engravings and colored plates. We consider that Mr. Sutton has conferred a real good upon the profession by thus rendering a knowledge of tumors, innocent and malignant, more general. We predict for it a large sale, which it certainly deserves.

DES PEURS MALADIVES OU PHOBIES. Par le Dr. E. Gelinus, Paris. Société d'Éditions

Scientifiques, 4 rue Antoine Dubois, 1893.

This is rather a remarkable book, dealing with dreads or fears of every kind. Although we do not remember having seen this subject before in print, every practitioner will recollect patients who had a morbid dread of being alone; of passing under a ladder; of dirt; of spermatorrhœa and so on. The author relates many interesting cases of this kind. The treatment of course consists of moral suasion.

TRANSACTIONS OF THE AMERICAN PEDIATRIC SOCIETY. Fifth session held at West Point,

N. Y., 24th, 25th and 26th May, 1893. Edited

by Floyd M. Crandall, M. D. Volume

V. Printed by Bailey & Fairchild, 1893.

This volume contains a number of interesting papers, but perhaps the most so are the President's address by our own esteemed Dr. Blackader of Montreal, and a paper on the Transmission of Tuberculosis to the Fœtus from either parent, by the late Dr. John M. Keating of Colorado Springs. Both of these papers are of the greatest interest. Dr. Keating thinks that in many cases tuberculosis is a congenital disease, and cites many strong arguments in support of his view.

SAUNDERS' QUESTION COMPENDS, No. 18.

Essentials of Practice of Pharmacy arranged in the form of questions and answers, prepared especially for Pharmaceutical Students. (Second edition revised.) By Lucius E. Sayre, Ph.G., Professor of Pharmacy and Materia Medica of the School of Pharmacy of the University of Kansas. Philadelphia: W. B. Saunders, 925 Walnut street, 1894. Price \$1.00.

The author has shown wonderful aptitude for condensing the whole subject of Pharmacy into a very small space. There are questions and answers on every conceivable subject within the domain of Pharmacy. It is especially suitable for students while reviewing their work.

A MANUAL OF THERAPEUTICS. By A. A. Stevens, A.M., M.D., Instructor in Physical Diagnosis in the University of Pennsylvania, etc. Philadelphia: W. B. Saunders, 925 Walnut st., 1894. Price \$2.25.

This is a neat volume of 435 pages divided into eight chapters as follows: Physiological Action of Drugs; Drugs; Remedial Measures other than Drugs; Applied Therapeutics; Incompatibility in Prescriptions; Table of Doses; Index of Drugs; Index of Diseases. The chapter on Applied Therapeutics is especially good. While not sufficiently exhaustive to take the place of the larger works, students and practitioners will find this little work very convenient for reference and thoroughly up to date.

PAMPHLETS.

THREE YEARS' EXPERIENCE WITH THE ELECTRICAL TREATMENT OF FIBROID TUMORS OF THE UTERUS, with a report of forty-four cases. By W. L. Burrage, A.M., M.D., Electro-therapist, Free Hospital for Women. Reprinted from The American Journal of Obstetrics, Vol. xxix, No. 3, 1894. New York: William Wood & Company, publishers, 1894.

ABSTRACT OF TWO ARTICLES TREATING OF PROGRESS IN MIDWIFERY. By Hunter Robb, M.D., Associate in Gynecology, Johns Hopkins University, Baltimore. Reprinted from the Maryland Medical Journal, March 31, 1894.

A CASE OF DOUBLE VAGINA, WITH OPERATION. By Hunter Robb, M.D., Associate in Gynecology.

SURGICAL SHOCK. By Charles P. Noble, M.D., Philadelphia, Surgeon-in-Chief of the Kensington Hospital for Women.

NON NOCERE. By A. Jacobi, M.D., New York. Reprinted from the Medical Record, May 19, 1894. New York Trow Directory, Printing & Bookbinding Co., 201-213 East Twelfth Street, 1894.

ACUTE PUERPERAL CELLULITIS AND TRUE PELVIC ABSCESS. By Charles P. Noble, M.D., Philadelphia. Reprinted from The American Journal of Obstetrics, Vol. xxix., No. 4, 1894. New York: William Wood & Company, publishers, 1894.

TENO-SUTURE AND TENDON ELONGATION AND SHORTENING BY OPEN INCISION; ADVANTAGES AND DISADVANTAGES OF THE VARIOUS METHODS. Clinical lecture delivered at the Jefferson Medical College Hospital. By H. Augustus Wilson, M.D. Reprinted from International Clinics, Vol. I., fourth series.

HABITS OF POSTURE A CAUSE OF DEFORMITY AND DISPLACEMENT OF THE UTERUS. By Eliza M. Mosher, M.D., of Brooklyn, N.Y. Reprint from the New York Journal of Gynecology and Obstetrics.

PUBLISHERS DEPARTMENT.**SECURITY AGAINST IMPOSITION.**

This heading is suggested by and is particularly applicable to the new advertisement of the Antikamnia Chemical Company, which appears in this issue. Antikamnia, while not suffering anything like other standard preparations from substitution, has still found it in some few instances. To the end, therefore, that there may not be even the breath of suspicion against Antikamnia, as well as to give every doctor the fullest confidence, the company has gone to the expense of withdrawing all the old stock from the market and replacing it with new. In the new form the drug is identically the same chemically and medicinally as it always has been, but every tablet bears imprinted upon it a monogram. (See advertisement.) Every package of Powder or Tablets is so wrapped and sealed and resealed as to render counterfeiting impossible. The entire profession should insist upon the safeguards provided, and there can be no question but that this action will be regarded with great favor by them.

The latest edition "Antikamnia and Codeine" tablets, can be obtained direct, or from your druggist. Each tablet contains $4\frac{3}{4}$ gr. Antikamnia and $\frac{1}{4}$ gr. Codeine.

"SIC TRANSIT."

As another exemplification of the old adage "Many are called and few are chosen," it is reported that the "Laborine Chemical Co." has come to grief. J. H. Chambers & Co., publishers of the *Medical Review*, secured an attachment for \$75.00, and upon the Laborine people taking an appeal, the appeal bond, filed at the time, was found to be even more worthless than the account it sought to stave off. It is known also that they are behind in their rent, and that there is nothing tangible for any of their creditors. Mercantile agency reports say "there is said to be little if anything left for other creditors."

This company originally attempted the promotion of their specialty under the name of Analgine-Laborde. But more recently, however, they have been taking the back track by exhibiting the words Analginé Laborde, cancelled and followed by the announcement that hereafter this "purely vegetable product" would be known as Laborine.

This is an illustration of the result that frequently follows efforts at pharmaceutical promotion, and medical journal publishers will find in many cases the experience of the *Medical Review*.