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THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF BRITISH AND FOREIGN MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO. JUNE, 1878.

Selections: Medicine.

MINUTE ANATOMY OF THE KIDNEY.

Royal Medical and Chirurgial Society.

* * * * *

The size and shapes of all casts are found to correspond with the excretory system of renal tubuli. Their most fertile source Dr. Southey believes to be the collecting tubes or ascending straight tubes of the third sub-division; in these are found the ordinary urate infarcta of new-borns, and the granular and fibrinous casts of chronic renal degeneration. The fine fatty streakings and lime deposits of old persons are seen more strictly limited to the transparent midway channels or down-loopers. The largest old fatty granular casts, which consist of cellular débris, leucocytes, fat dottings, and urinary salts, are doubtless cast or moulded in the gathering mains close to the orifices of the papillæ, but cannot be held to be secretions from the tortuous secreting tubes deprived, as has been by some supposed, of their epithelial linings. The value of casts in deciding the diagnosis and estimating the advancement of renal diseases has been much over-rated. Their different forms and appearances are derived in part from the materials of which they are composed, but in greater part are due to the length of time during which the gelatinised plugs of fibrinous material derived from the blood-serum have resided in the passages whose mould they take, the degree in which they have been soaked with urinary salts and stained with urinary pigments, and become degenerated. After many years' vain search for them, nothing

like a desquamative shedding of the epithelium lining a tortuous tube has ever been observed by the author. And although red and white blood-cells, leucocytes, and escaped nuclei have been constantly observed in acute nephritis entangled in fibrinous plugs, the actual linings of the straight collecting tubes, with their low, sessile, columnar epithelium, have as such never been recognized by him. To form any clinical inference as to the nature and extent of renal disease from the sediment of the urine and tubal casts is about as unsafe as forecasting the issue of bronchitis or pneumonia by the expectoration. It is not that the casts or the character of the expectorated matters have no clinical value, but they have a relative one only. In renal disease, the casts should be appraised side by side with the diurnal urea excretion, and considered in reference to the quantity of albumen excreted at different periods of the complaint.—Dr. George Johnson said that he differed almost totally from Dr. Southey's statements, which, if true, would show that there was very little diagnostic value to be set upon the study of renal casts. The author's main argument rested on the assumption that all the convoluted tubes were connected with the looped tubes; but this could not be proved, and Dr. Johnson much doubted it as a fact, for he was quite certain that casts formed in the convoluted tubes do appear in the urine. For example, in cases of renal hæmorrhage from turpentine, casts appear in the urine formed of blood, which it is perfectly certain, comes from the system of the Malpighian capillaries; such casts are moulded in the convoluted tubes, and often appear quite convoluted themselves. Casts formed of white

blood-corpuses must also proceed from the exudation of leucocytes from the Malpighian tufts, for no changes are found in the tubules indicating their passage through the walls and epithelium. The majority of fatty casts, too, had their origin in the tubes of the cortex, which was pre-eminently the seat of fatty degeneration. He was surprised at Dr. Southey's statement that he had never met with an epithelial cast, for he had seen casts covered with undoubted glandular epithelium in a vast number of cases. A common instance of epithelial shedding was met with in cases of obstructive jaundice. If the epithelium could not be got rid of, every inflammation of the kidney, even the slightest, might lead to fatal results from blocking of the channels. Desquamation implied formation of new cells as well as shedding of the old. Dr. Johnson also stated his firm belief that the large size of casts was an indication of their formation in tubes denuded of epithelium; whilst, on the other hand, small flattened casts were found when the epithelium remained and was swollen. He did not agree with Dr. Southey that the large hyaline casts were most numerous in acute cases; they occurred mostly in chronic cases, and their abundance was in direct relation to the amount of atrophy and disorganization of the kidney present.—Dr. Southey, in reply, said that, had he entered into pathological details, he should certainly have drawn attention to the fact that the products of renal inflammation could be absorbed as Dr. Powell had suggested; but his main object had been to show that the existence of the looped tubes (which, from their number, he believed were connected with all the excretory tubes) was *à priori* evidence against the passage through them of casts formed in the larger convoluted tubes. Granular material and detritus, no doubt, did traverse them, and in chronic parenchymatous nephritis the excretory tubes were found blocked with such products; but he had never seen anything like an epithelial cast which could have been formed by desquamation of the secreting epithelium. The convoluted tubes varied much in size in their course, and he had not met with casts reproducing their characters in this respect. As to the formation of small casts between swollen

epithelium, that was pure speculation, and he believed himself that these finer casts came from the looped tubes.

INTESTINAL WORMS IN CHILDREN.

Medical Society of London.

Dr. Sansom read a paper entitled "Notes on some of the Common Disorders of Children." They were suggested by an experience of nine years at the North-Eastern Hospital for Children. More than half the cases which came under treatment were those of disorder of the alimentary canal; and, taking 500 cases promiscuously, 145 (or 29 per cent.) were disorders due to the presence of intestinal worms. The general prevalence is, no doubt, much higher. The symptoms produced by the parasites are divisible into a large class of direct and a small class of reflex phenomena, and the diagnosis is made by the direct observance of the parasites in the dejecta or about the body. The chief intestinal parasites of children in this country are the *ascaris lumbricoides* and the *oxyuris vermicularis*; the ova of the former being introduced by contaminated drinking water, and those of the *oxyuris* by direct communication or by ingestion. An individual once affected becomes a constant source of self-contamination, for the ova are conveyed by the fingers from the neighbourhood of the rectum to the mouth. Most of the symptoms produced by these parasites are the direct results of the irritation by themselves or their ova, so that not only do they produce the symptoms referred to in the rectum and intestines, but they cause unhealthy sores about the groins, whitlows and ulceration of the fingers, irritation of the nares, a well as many of the forms of impetigo. Stomatitis, hypertrophy of papillæ at root of tongue, pharyngitis and tonsillar ulceration could also be attributed to their direct irritation. The peculiar cough of vermiferous children was due to local irritation of the fauces. Reflex phenomena, as epilepsy, hemicrania, and chorea, were most common in the hosts of *lumbrici*. Santonine for *lumbrici*, aperients and enemata for *ascarides*, were indicated as the best line of treatment; a concurrent tonic treatment, and prophylaxis in the enforcement

of absolute cleanliness, were insisted on.—Dr. Edis spoke of the frequency with which vaginal leucorrhœa in children was due to the thread-worms creeping into the vagina. He had seen grave effects resulting from the use of a solution of carbolic acid as an injection. He referred also to possible infection from cats. Dr. De H. Hall said the central streak on the tongue was met with in most abdominal affections. He commended a Swiss baker who had announced his determination not to suffer his bread to be handled by intending purchasers. He advocated the use of iron both by the mouth and by the bowel, after the employment of free purgatives, in the treatment of oxyurides. Mr. Coles spoke of the frequency with which intestinal worms are met with among children in China, the lumbricus being most common. He advocated the free use of salt with food.—Mr. Wordsworth said that during a stay of two years in the West Indies he had not met with a single instance of the common thread-worm. Lumbrici are very common, and he mentioned a case of tetanus which had recovered after vomiting one of these worms.—Dr. J. Brunton was quite certain that these parasites are incompatible with perfect health. He first employs purgation to clear out as many worms as possible, and then gives some tonic to enable the child to digest its food. He advocated repeated doses of linseed oil in emulsion.—The President said that the skin will respond to reflex irritation, erythema in some cases, eczema in others, and so on. He mentioned an obstinate case of labial eczema due to irritation of a carious tooth. Copaiba was useful in the treatment of thread-worm.—Dr. Main said that in cases in which santonine had failed turpentine and castor oil were useful.—Dr. Sanson, in reply, thought the skin affections were the immediate result of the irritation of the worm, the ova having been found in the discharges. The ascaris mystax of the cat had been met with in man. Salt was certainly indicated; any article of diet, such as brown sugar, which goes through many hands, is to be suspected.—

London Lancet.

The American Medical Association meets in Buffalo on June 4, 5, 6, and 7, commencing on Tuesday, June 4th, at 11 a.m.

ON PRURITUS VULVÆ AND DIABETES.

BY ALFRED WILTSHIRE, M.D., M.R.C.P., LONDON.

A few years ago, at a meeting of the Harveian Society, I called attention to the frequent association of pruritus vulvæ with diabetes. As continued observation confirms and strengthens the statements then made, and as my observations have never been made known otherwise than as above and stated in my lectures, I desire again very briefly to call attention to and emphasise the fact that pruritus vulvæ is often the only symptom of diabetes, and to point out the desirability of a systematic examination of the urine for sugar in suspicious cases.

Diabetes is only one among many affections with which pruritus vulvæ may be associated; but notwithstanding that it is mentioned in some books as a cause of vulvar itching, it is nowhere, that I am aware of, stated with adequate prominence.

Excepting itching, there may be no symptom whatever of diabetes—neither polyuria, loss of flesh, nor large appetite; and it is not therefore a matter for surprise that the underlying diabetic affection frequently remains unsuspected.

The observations of friends who have become acquainted with my views are confirmatory of them, and show that there is a more frequent connexion between diabetes and pruritus vulvæ than is generally believed. Accordingly, it seems desirable that further attention should be directed to the fact, seeing the gravity of the more important affection. It is hoped that a wider diffusion of the knowledge may prove useful to many.

Though matter of high interest, I am not concerned at present to discuss the pathogeny of diabetes; but regarding it from a purely clinical aspect, it is difficult to avoid the conclusion that there are at least two (if no more) forms of diabetes; or, to put it in another way, that sugar, or some allied body equally capable of reducing copper, on the test being applied in the usual way, may often be found in the urine of stout, florid (gouty) persons, as well as in the lean, wasted people who are looked upon as classical types of the disease.

I have at present under my care at St. Mary's Hospital an excellent illustration of this fact. When the patient, a stout, florid, middle-aged woman, first came under my care some months ago, she was tormented with violent itching of the privates. Suspecting diabetes, I had the urine examined, and then, and ever since, it has contained an abundance of sugar. She rarely passes more than a normal amount of urine, looks as hearty as can be, and from the first application of the treatment—a borax lotion—has almost lost the itching. As the object of this short paper is merely to put others on the track of diabetes through the pruritic symptom, I will add no more, but await hopefully the statement of the experience of others.—*Lancet*.

ON AN IMPROVED METHOD OF TREATING FACIAL PARALYSIS.

BY WILLIAM A. HAMMOND, M.D.

In no disease are prompt measures more necessary than in facial paralysis. A few weeks', and sometimes a few days' delay are sufficient to diminish the conductivity of the nerve, and the contractility of the paralyzed muscles, besides initiating a state of tonic rigidity in the latter, most prejudicial to the obtainment of a complete cure.

The paralysis of the muscles supplied by the facial nerve, when induced by cold, I have heretofore found to be generally manageable by the use of strychnia, electricity, passive exercise, and the support to the affected side of the face, given by a little hook placed in the angle of the mouth and fastened to the ear by an elastic band. These measures are by no means to be discarded, and one of them, strychnia, is to be even more energetically employed. The improvement to which I refer, in fact, consists in the administration of strychnia in increasing doses to the point of rapidly—as rapidly in fact as is consistent with prudence—bringing the patient under its full physiological influence.

For this purpose I make use of a solution of the sulphate of strychnia in the proportion of one grain to the ounce of water. Every ten minims of such a solution contain 1-48 of a grain of the medicine. Generally I begin with ten minims of this solution three times a day

for the first day; the next day eleven minims are given three times; the next twelve, and so on, till the patient experiences a sensation of cramp or rigidity in the legs, or in the muscles of the back of the neck or of the jaw. Usually the cramp is first felt in the calves of the legs. The further administration is now stopped, and, if necessary, on the following day the solution is given as before, in doses of ten minims, and the doses are again run up to the extent of producing the muscular cramp.—*St. Louis Record*.

OBSTINATE HICCOUGH CURED BY EPIGASTRIC COMPRESSION.—In the *Lyons Medical* is a notice of a case of hiccough, occurring suddenly in a man suffering from blenorrhagic urethritis, and lasting without interruption, either by night or day, for three weeks. Morphinated blisters and hot iron points to the epigastrium had been used in vain, as well as morphia injections in the course of the phrenic nerves, touching the back of the throat with liquid ammonia, and internally ether, bromide of potassium, bromide of camphor, chloral, sulphate of atropia, sulphate of quinine, musk, &c. Compression of the epigastrium arrested it, but as soon as the pressure was intermitted it recurred. Pressure was therefore permanently kept up by one of Petit's tourniquets, and had to be maintained for eight days, a recurrence of the hiccough following its removal every time within that period. It was subsequently necessary to replace it several times to ward off recurrences, but the spasms were ultimately definitively arrested.

TREATMENT OF INTERMITTENT FEVER BY CARBOLIC ACID.—Stern gave carbolic acid in recent cases as well as in old cases relapsing after quinine. He prescribed it according to the formula of Hehle: carbolic acid 0.40, distilled water 180.00 (or 1 in 72); one tablespoonful three times a day. Out of twenty cases so treated, fourteen were cured after a single dose of this solution, four after two doses; two cases resisted the treatment. Six were quotidian fevers, eleven tertian, and two quartan; in these last, there was no return of the attack after the beginning of the carbolic acid treatment; in the tertians, there was ordinarily one more attack, in the quotidian, two more.—*Gaz. Méd. de Strasbourg*.

SIMULATION OF FEVER.—Dr. Sellerbeck, (*Berlin. Klinik Wochenschrift*, No. 3, 1878) had a patient suffering from stenosis of the cardia and ulcer of the stomach, in whom he occasionally found a temperature of $39^{\circ}\cdot 4$ ($102^{\circ}\cdot 9$ Fahr.) and a pulse of 120, with respirations 24 in the minute. Not being able to find any local trouble to account for this, he thought that the patient was malingering, and one day when the thermometer placed in the axilla registered $38^{\circ}\cdot 5$ ($101^{\circ}\cdot 3$) the temperature in the rectum was found to be only $37^{\circ}\cdot 8$ (100°). He knew that by frequent deep respiratory movements he could raise his own pulse from 75 to 130, but did not know how to account for the elevation of temperature. The patient, however, admitted that when the thermometer was placed in the axilla under pretext of feeling cold, she was covered with the bedclothes, and then making a fold of her chemise in the armpit and breathing rapidly, she could cause sufficient friction between the bulb of the thermometer and the chemise to raise the index considerably. Sellerbeck subsequently experimenting on himself, found that he could thus make it mark 46° ($114^{\circ}\cdot 4$). By friction against the skin, he could only, on account of the cold produced by evaporation of the sweat, even with a very dry skin, raise it to $42^{\circ}\cdot 2$ ($107^{\circ}\cdot 6$).

Surgery.

THE TREATMENT OF SPINA BIFIDA BY MORTON'S IODO-GLYCERINE SOLUTION.

A case brought before the Clinical Society of London about the end of January last, served as a text for the discussion of the merits of this method of treatment. Mr. A. Pearce Gould exhibited the case and the opinions of eminent surgeons which it elicited are worthy of note. Up to the end of 1876, Dr. Morton of Glasgow had been able to collect a record of fourteen cases treated by the method he has devised, and in eleven of these the issue had been successful (*Vide CANADIAN JOURNAL OF MEDICAL SCIENCE* March, 1877, page 90).

In the case detailed by Mr. Gould, the child was brought to the Hospital for Sick Children when eighteen months old. The tumour was the size of a cricket ball, sessile, with the usual characters of spina bifida. An opaque band was seen along the middle line of the lower three-fourths of the tumour. On September 15th, 1877, the tumour was tapped with a small hydrocele trocar at the upper part just to one side of the middle line; six drachms of fluid were removed, and half a drachm of Morton's iodo-glycerine solution was injected, the opening being closed with collodion. For the first few days the tumour became firmer and smaller, but at the end of a fortnight it had returned to its former condition. On October 5th tapping was repeated and one drachm of the iodine solution injected. Same result. On November 5th, operation repeated, two ounces and a half of fluid removed and two drachms of the solution injected. The sac became very tense, red, hot, and tender; fluctuation persisted for a week, but on the ninth day a marked change was noted; the tumour was smaller, flaccid, elastic, but not fluctuating, and did not become tense when the child cried. On December 14th, there being still distinct fluctuation in the now thickened cyst, it was again tapped and emptied by the removal of six drachms of a yellow, viscid, highly albuminous fluid; communication with the spinal canal was completely obliterated. One drachm of the iodine solution was injected,

THE SOURCE OF THE RESPIRATORY BRUIT.—In the second edition of his work on Auscultation and Percussion, Dr. Samuel Gee says: "I may as well at once declare that I hold to Beau's doctrine in this matter. Beau's theory is the following:—The lungs in the chest are distended; the tubes are well open, apt for conduction and reflection. The passage of the breath through the narrow glottis into wider spaces above and below, produces sonorous fluid veins, inspiratory and expiratory. The nostrils, the mouth, and the fauces partake in the production of the respiratory sound; however, for present purposes, it may be deemed to be wholly glottidean. Now this glottidean breathing murmur is conducted down the air tubes just as the low or whispered voice is carried and vesicular breathing loses the reverberating hollow quality in consequence of the badly conducting material of the spongy textures of the lung." Dr. Gee, of course, admits, however, the vesicular character of the crepitant râle.

well manipulated, and allowed to escape. The tumour had since then gradually shrunk, and now presented a thick pad of skin, quite dense at the lower part, softer above where there was a small spot which still fluctuated, from this Mr. Gould withdrew about half a drachm of yellow turbid fluid on the 23rd of January, 1878.

After each operation, the temperature rose to 101° and 102°·8 and continued above the normal from two to six days. The after treatment consisted in thickly smearing the tumour with collodion each morning and supporting it with wool and a bandage. Out of twenty-three cases of spina bifida examined by Mr. Gould, nerves had been found in the sac in twenty cases, in two they were absent, and in one their presence was doubtful. They occupied the middle line, the position of the opaque band in this case. The fluid removed at the first three operations was colourless, becoming slightly turbid on standing, of specific gravity 1011, faintly alkaline, containing a trace of albumen, chlorides, and phosphates. With Fehling's copper solution it gave no reaction; but Dr. Dupré analysed it, and after concentration, got distinct evidence of sugar. In fluid of spina bifida, or that escaping from the skull in fracture, sugar must not be supposed to be absent unless the tests be applied to the fluid after evaporation. On pouring some of the iodo-glycerine solution on to some spinal fluid in a narrow glass, it was found that the solution went to the bottom and did not mix. Mr. Gould thinks this also occurs in the sac, for the fluid oozing from the puncture after injection was unstained with iodine. There was considerable difficulty in arresting the oozing of cerebro-spinal fluid, which was so dangerous if allowed to continue. Mr. Callender (the President) suggested that it would be found useful to introduce the trocar and canula through and beneath the skin some little distance to the side of the tumour. In this way direct puncture was avoided and compression after removal of canula was more effectual in stopping oozing. He remarked that a gentleman, a subject of spina bifida, who had formerly been under Sir Astley Cooper, died under his care at the age of seventy-four, having led an active professional life, with bladder and rectum troubles and de-

fective innervation of lower extremities. Mr. Howard Marsh believed that Morton's plan would prove a valuable addition to the surgery of childhood.

Mr. Thos. Smith thought it the very best method of treatment. The injection of watery solutions of iodine was very rarely successful. It was interesting to learn that the difference in the result of the iodo-glycerine solution was probably due to its remaining in the lower part of the sac, and its effects being therefore more limited. He had employed it successfully in four or more cases. Mr. Holmes in his *Diseases of Children* speaks of a man with spina bifida, aged forty-three, who survived an operation for stone. He himself was consulted by a man of middle age with spina bifida, who was able to perform all his professional and domestic duties. He could not say what might be the ultimate result in cases treated by this method, but he was bound to say that in estimating the value of the result in such cases as he had cured by other means, it would have been better for the patients had they not survived the treatment.

ABORTIVE TREATMENT OF FURUNCULUS.—Dr. Lieven observed at the Petersburg Medical Society (*Petersburg Med. Woch.*, Dec. 29) that all modes of treatment hitherto tried (such as early incision, cauterizing, and cold or warm applications) have failed to arrest the further development of furunculus that has once commenced. The following procedure, however, brings it to a stand: A burning, pricking, itching, suddenly occurring in a normal portion of the skin, announces the commencement of the development of the furunculus, and on the same day a small and quite superficial induration can be felt at the spot. If the skin be now superficially scraped with a small knife, so that a drop or two of blood may be pressed through the epidermis, no furunculus will be developed. This result would seem to show that the affection originates in the uppermost layer of the corium, and perhaps in the capillaries of the papillæ, and not, as hitherto received, in the subcutaneous connective tissue, with succeeding necrosis of the corium and epidermis. Disturbance of the digestive organs (frequently diarrhoea) always precedes or accompanies furunculus; but a plethoric or decrepit constitution is no necessary condition, as it may occur in one that is quite normal.—*Med. Times and Gaz.*

APPLICATION OF TRUSSES.

When you advise any of your patients to use a truss you should always make it a rule to superintend its first application. If you cannot be present yourself, give your patient the following *directions*. (1) Never accept a truss until you get one which fits. (2) Try it by putting it on, and (a) stooping down and rising up suddenly; (b) by coughing violently and persistently; (c) by separating the limbs and stooping; (d) by crossing the limbs and sitting down; (e) by going through all kinds of motions. Of course the truss is not a proper one if the hernia slips away from it in the course of any of these motions.

In wearing a truss the following *precautions* must always be had. (1) The patient must never take off the truss till he or she is in the recumbent position. (2) Before putting it on again the parts must be rubbed until they are all aglow, so that an active circulation and full secretion are maintained. (3) The truss must be taken off the last thing before the patient retires, and put on the first thing in the morning. (4) In the case of a child the truss should be worn all the time, both night and day, after the first feelings of discomfort have passed away. At first it must of course be taken off two or three times, while the skin is thoroughly rubbed and anointed, and then put on carefully again. If these rules are conscientiously adhered to, a cure may be expected in the course of two or three years. The truss, at any rate, should not be taken off sooner than that. I may say, in closing, that permanent cure is much more likely to ensue if a hard than if a soft pad had been employed.—*Dr. D. Hayes Agnew, in Phil. Med. Times.*

POST-PARTUM HÆMORRHAGE. — Various remedies have from time to time been recommended in the *British Medical Journal* for the treatment of *post-partum* hæmorrhage; but I do not remember to have seen large doses of turpentine ever advocated. Some time since when discussing the subject with a friend, he told me he knew an old practitioner of large midwifery experience who never went to a case without taking two draughts, each containing half an ounce of spirit of turpentine; and he never knew them fail.—JAS POLLARD, Torquay.

Midwifery.

From *Gazette des Hôpitaux*.

PHLEGMON OF THE PERIVESICAL OR PRE-PERITONEAL CAVITY OF RETZIUS.

There exists between the anterior wall of the abdomen and the peritoneum a space limited anteriorly by the recti muscles; behind, by the peritoneum and the *fascia transversalis*; above, by Douglas's folds; below, by the summit of the bladder in its empty state; and laterally by the arcades of Douglas's folds. This space, to which the name of pre-peritoneal cavity or cavity of Retzius has been given, may be the seat of several pathological conditions, and especially of phlegmons, either primary and spontaneous, or consecutive and allied to congestive or inflammatory states of the organs contained in the abdomen or pelvis, and which present special characters in all cases. It is to the study and description of these phlegmons that Dr. J. M. Castanedo-y-Campos has devoted his inaugural dissertation, which constitutes a veritable monograph, the principal conclusions of which we deem it of interest to make known. . . . In cases observed by M. Castanedo-y-Campos either in M. Guyon's wards, or in those of M. Constantin Paul, or of M. Dujardin Beaumetz, the phlegmasia had for its cause or point of departure either an inflammation of the prostatic tissue, or an antecedent typhoid fever, or some menstrual trouble, and in one case no cause could be ascertained.

The signs of this affection are, in the beginning, those of urinary retention or exceptionally those of an intestinal obstruction, accompanied by pain in the hypogastric region which radiates as in colic. Shortly afterwards a median hypogastric tumour appears; the urethra remains permeable, and the evacuation of the urine in nowise affects the volume of the tumour. The functional symptoms consist, on the part of the bladder, in dysuria or anuria, but the urine remains normal; on the part of the rectum, in constipation or diarrhoea. The general symptoms are: fever, vomiting, chills.

The course of the disease varies a little as to duration and as to the initial symptoms. The

termination may be by resolution, by induration, or by suppuration. The opening of the abscess may be through the skin, into a neighbouring hollow organ, or into the peritoneal cavity. In the only autopsy which had been made, the suppurating phlegmon had opened into the peritoneal cavity and had determined a fatal peritonitis and a partial destruction of the recti muscles of the abdomen at their inferior part. In other cases the pus made exit through the walls of the rectum or through the skin. It is easy to conclude from these facts that the prognosis must be grave.

The treatment of the swelling, in its inflammatory period, should be the same as that for other phlegmons: rest, restricted diet, emollients, &c.

When fluctuation has been recognized, you should hasten to lay open the swelling; if other purulent collections exist in communication with it, counter openings should be made.

Lastly, it must never be forgotten that it is possible to obtain resolution or induration, and consequently you should always insist upon early treatment.

[During the past year M. Constantin Paul and others have reported to the various societies of Paris several cases of hæmatocele in this pre-peritoneal cavity or canal of Retzius, and we ourselves have had a case under observation which terminated spontaneously in resolution. —ED. CAN. JOUR.]

PHYSOSTIGMA FABÆ IN THE CONVULSIVE DISEASES OF CHILDREN has been used with marked success by Dr. J. S. Trezevant (*Transactions of South Carolina Medical Association*, 1876) in several cases. The convulsions were readily controlled after every other remedy was fully tried in vain.

Dr. McLawrin (*Edinburgh Medical Journal*, vol. 11, p. 319) reports a remarkable case of tonic convulsions persisting for many months, attacks recurring several times a day, in which physostigma greatly moderated the attacks and effected a cure in a few weeks. The dose was gradually increased until the equivalent of four grains of the bean had been taken four times a day. In another case, a little girl $4\frac{1}{2}$ years old, who had had convulsions four or five times a day for nine months, not a single attack occurred after the first dose of this medicine. — *Virg. Med. Monthly*.

Hospital Reports.

HOUSE OF PROVIDENCE.

SEPARATION OF THE EPIPHYSIS OF THE CAPUT FEMORIS.

For the privilege of reporting a case of this rare accident we are indebted to Dr. Senkler, under whose care it came, and to Mr. Jones, clinical clerk, for its transcription.

From the statement of the child, it would appear that she fell directly upon the outer side of the thigh, which circumstance, in Rodet's opinion, in which Hamilton concurs, should have given rise to an extra-capsular fracture; but, had some observant person been present at the time, it might have been noticed that the concussion was transmitted from the front as well, which Rodet admits would then be likely to produce an intra-capsular injury. The occurrence of this rare accident, although not admitted by Hamilton, in the absence of *post-mortem* proof, is mentioned by Liston, and seeming instances have been recorded by Willard Parker, Mr. South (in a note to Chelius's Surgery), Dr. Post, Sayre, and Hamilton himself.*

February 2nd.—Mary W——, aged fourteen, of the House of Providence, while sliding down the balustrades fell a distance of about eight feet upon the right trochanter major.

Drs. Hobbey and Cameron examined the patient immediately after the accident and discovered shortening of right lower extremity from one-eighth to one-fourth of an inch; no eversion or inversion of the foot, no crepitus, but considerable pain on movement; thought if fracture existed it must be impacted intra-capsular.

February 3rd.—Dr. Senkler made an exam-

* Mr. Hornidge, in the article on Fractures in Holmes' System of Surgery, says: "Although it (separation of epiphysis) has been demonstrated, by *post-mortem* examination, only at both ends of the humerus, femur tibia, and fibula, and the lower end of the radius, yet it has been diagnosed during life in other parts of the body. . . . The epiphyses which enter into the formation of the ginglymoid joints unite with the shaft of the bone sooner than those which correspond to the enarthrodial; therefore separation of the latter is the more frequent."

ination, and found the thigh slightly flexed and somewhat adducted, the knee of the injured limb being drawn across the sound one, toes inverted, the rigid muscles firmly holding the thigh in this position. There was pain and tenderness in front of the hip joint, and the child was feverish, and very unwilling to be moved.

February 4th.—The child's condition the same as on previous day. Upon causing her to stand up, the injured limb maintained the same position—slight flexion of thigh and leg adduction of thigh, and inversion of toes. She was quite unable to bear weight on the injured side, although anxious to do so to avoid further examination.

Dr. Hopley, who examined the case with Dr. Senkler, administered chloroform, and as soon as muscular power was overcome by the anæsthetic, the leg lay flat upon the bed, and the foot turned in or out indifferently. The mobility of the affected joint was found to be complete.

Upon flexing the thigh and rotating, the knee being turned over the abdomen, an obscure crepitation was discovered. By making extension from the ankle, the left hand being placed over the hip joint, with fingers pressed against the spinous process of ilium, the same crepitus was both felt and heard each time the limb was extended and relaxed, and the trochanter was felt to move up and down to a limited extent. The crepitus was not that of freshly broken bone, but rather conveyed the impression of friction between roughened cartilaginous surfaces. After this examination, there existed shortening to the degree of five-eighths of an inch.

Diagnosis: Separation of epiphysis of head of femur. Treatment: Liston's long splint was applied; the foot of the bed was raised about seven (7) inches, and extension made by adhesive plaster and a weight of nine (9) pounds running over a pulley.

The limb was left undisturbed for six (6) weeks, and on March 18th, the splint being removed, a shortening of barely one-fourth of an inch was discoverable; no pain on movement of the joint. Upon applying Bryant's and Nelaton's test, the trochanters were found to be on the same level, and no evidence of separation

remained. The adhesive plasters were re-applied and attached to a weight of six (6) pounds with cord and pulley, but the long splint was now dispensed with. On March 30th, eight weeks from the accident, everything was removed.

On April 11th, Dr. Senkler made a final examination; the patient had then walked out on to the balcony with the aid of a chair. She could almost bear the whole weight of the body on the injured side—the inability to do so completely is not owing to pain, but to muscular weakness. Careful repeated measurements with the tape give shortening of about a quarter ($\frac{1}{4}$) of an inch. Cowling's and Bauer's method of suspending a plumb-line from the vertebra prominens revealed no shortening, as the cord ran vertically through the internatal fold, while the soles of the feet appeared to rest evenly upon the ground.

MEETING OF SURGICAL SOCIETY OF IRELAND, MARCH 1ST, 1878.

RUPTURE OF THE TENDON OF THE GLUTEUS MAXIMUS.

BY ROBERT M'DONNELL, M.D., F.R.S.,

President of the Royal College of Surgeons, Ireland.

Martin Brady, aged 63, admitted into Steevens' Hospital December 26th, 1877; healthy; well built; personal and family history good. He stated he was accompanying one of his carts which was heavily laden behind. To prevent the cart toppling backwards, he took hold of the shafts projecting from behind, but in passing through a gateway, the cart was thrown back, and he was brought violently down to an almost sitting position, and then made a strong effort to throw the cart forward, the man being exactly in the position which was calculated to put the greatest strain upon the gluteus maximus muscle. At that moment, he felt as if he had received a severe blow from a stone and heard a sharp snap, which he described as like a clap of the hands. He immediately experienced acute pain about the fold of the left nates, which so disabled him that he fell on the ground. He received no treatment from the date of the accident, October 5th, until he was received into the hospital,

December 24th. On admission, his condition was as follows:—In the gluteal region, the gluteus maximus on the side of the injury was soft, flabby, and in fact completely paralysed; and near to the insertion where the muscle joins its tendinous expansion from the line of the great trochanter and linea aspera, there was a thickened welt, indicating the place where the process of union was commencing to take place. Accompanying these symptoms, there was a marked paralysis of the limb. The palsy was much more complete as affecting the extensor muscles of the leg. It occurred to me that the sciatic nerve had been injured, but on examination, it was found that all ordinary sensibility was quite perfect. As such cases are not often met, they must be treated on general principles. The patient was kept quiet, but allowed to move about with the limb straight, so as to keep the ends in apposition. He was now able to walk a good deal better than when he entered the hospital. The paralysis of the limb had very much improved, and the patient was now able to walk very well with one stick. The complete paralysis of the muscle was remarkable, and looked almost like an effort on the part of nature to take tension off the muscle, to allow it to remain passive and quiescent while union is going on. The Dr. mentioned other cases of ruptures of different tendons. There did not appear to be any exact rule with regard to the place where the muscle would give way. In the case described, it appeared, so far as one could make out from careful examination, to have torn at the part where the tendinous expansion and the muscular fibres meet. The snap or rupture of a tendon seems to be very constantly accompanied by a sensation, as if the patient had received a smart blow or kick.

In the discussion which followed, Mr. H. G. Croly said, he had not seen, nor did he know of any recorded case of rupture of the tendon of the gluteus maximus. But it struck him that the paralysis might be explained in this way: that the great violence which was necessary to rupture so powerful a tendon, might also have stretched or partially torn the sciatic nerve, as the distance from the nerve to the tendon was not great. Of the rupture of other tendons, he had seen a few examples. This winter, he had

a case of rupture of the plantaris. The patient was a clergyman, and in going up the steps of his church, he turned round suddenly to see if anyone had given him a blow of a stone in the calf of his leg. As he saw no one near him, he rubbed his leg. Subsequently, he consulted a medical practitioner, who gave him a liniment to rub on the leg, which, however, continued very painful. He afterwards consulted him (Mr. Croly). From the cases he had seen of rupture of the plantaris tendon, he thought the tendon generally ruptured about four inches up from the os calcis, and not at all near to the belly of the muscle. Of course, that was a well-known accident in ballet-dancers.

After several other members of the society had joined in the discussion, the President said, in reply, with regard to the observations of Mr. Croly about the paralysis depending upon some rupture or injury to the nerve, he could not adopt that view, for the reasons he had already given. He thought that if the nerve were in any degree torn, or blood effused into its texture at the time of the injury, as it was a compound nerve with both motor and sensitive fibres, they would expect to find some paralysis of sensation in the lower limb, as well as some paralysis of motion, while there was nothing of the kind. Therefore he thought they must regard it as one of those forms of reflex paralysis which they knew sometimes occur. Sir James Paget had given some cases in which a severe contusion had been followed by paralysis of muscles in the neighbourhood. He (Dr. McDonnell) thought the case he had related must be a case of that kind. They knew that the nerves and bloodvessels were capable of undergoing a great deal of extension without giving way.—*Summarized from the Medical Press and Circular.*

ABDOMINAL COMPRESSION IN ASCITES.—In the *British Medical Journal* for 20th April, 1878, Dr. Stephen Mackenzie, of the London Hospital, reports two cases of obstinate ascites successfully treated by means of a bandage or tightly fitting abdominal supporter. In the first case, the use of the bandage was supplemented by tonics, but in the second, the credit of the recovery appears to be due to the supporter alone, as no medicine was administered except the *mistura rubra* of the hospital (burnt sugar and water). He commends the plan most highly.

EXAMINATION QUESTIONS—COLLEGE OF PHYSICIANS AND SURGEONS,
ONTARIO, 1878.

CHEMISTRY—1st Year.—J. MORRISON, M.D., M.A., *Examiner.*

1. What is heat? How is it measured? Define latent heat; specific heat; atomic heat; and the thermal unit. Explain the construction and use of the thermometer and convert 25° Fahrenheit to centigrade $V 75^{\circ} C$ to F.
2. Define specific gravity, and show how the sp. gr. of liquids and gases is found. Explain the construction and use of the hydrometer, the densimeter, and the eudiometer.
3. Classify the non-metallic elements as to their quantivalence. Name the following compounds, HBr, HClO₃, PH₃, H₂O, NH₃, H₂S, and state the functions H performs in each.
4. How is the composition of the atmosphere determined as regards N and O? What other elements or compounds are found in it? What functions do they perform, and how are they detected.
5. Give the composition, mode of preparation, properties and uses of hydrochloric acid, ammonia, sulphuretted hydrogen, nitrogen monoxide, sulphurous acid. Explain the reactions in each case.
6. What are the sources of I and P? How are they prepared? What compounds do they form with H? Describe the different modifications of P. How much phosphoric anhydride can be obtained by burning 20 grains of phosphorus.
7. What are the chief ores of arsenic? Name its oxides, and state how they are prepared. Point out the general chemical relations of As., P and N compounds.
8. Describe Marsh's test for arsenic.

CHEMISTRY—2nd Year.—J. MORRISON, M.D., M.A., *Examiner.*

1. Classify the commonly occurring metals as to their quantivalence. Define and give examples of the following, a dyad radical, an anhydride, a hydrate, an acid salt.
2. Explain by diagrams or equations the preparation of potassium iodide, potassium chlorate, mercuric chloride, ferric sulphate, and ammonium chloride. Describe their properties and uses.
3. Write down the typical formulæ of the most important cyanogen compounds. Describe the mode of preparation, and chief properties of hydrocyanic acid.
4. Give a short account of the principal phenomena of fermentation. Name its five principal forms and the products of each.
5. Name the properties and mode of preparation of ethyl alcohol, and state the chemical changes which occur when a primary alcohol passes to the corresponding aldehyde and acid.
6. How is valerianic acid artificially prepared? In what natural bodies is it found, and what is its chemical relation to amylic alcohol?
7. How are ethyl nitrite and chloral hydrate prepared? What are their formulæ, properties, and uses?
8. How are quinia disulphate and strychnia prepared? Give the chemical characters of each, and show how salicin may be detected in the former, and brucia in the latter.

PRACTICAL CHEMISTRY.—J. MORRISON, M.D., M.A., *Examiner.*

1. What impurities are found in sulphuric acid, acetic acid, magnesium sulphate, and potassium carbonate? Give the tests for them.
2. What are the tests for hydrocyanic acid? How much anhydrous hydrocyanic acid is there in an eight ounce bottle of medicine, six fluid drachms of which precipitated with a solution of nitrate of silver, shall yield four grains of dry cyanide of silver.
3. Give three tests for salts of zinc, three for manganese and four for lead. Give the reactions in each case.
4. How is potassium chloride detected in potassium bromide, and how are iodides removed from a solution containing chlorides and bromides?
5. How is potassium iodate detected in potassium iodide, and how separated from it?
6. Describe Reinsch's test for arsenic. Under what circumstances may its indications prove fallacious? What is the peculiar value of Fleitmann's test (*i.e.*, the action of AsH₃ on Ag, NO₃).
7. How would you detect mercuric oxide in "red lead," calomel in corrosive sublimate, and lead carbonate, in barium sulphate?
8. Give tests for albumen, bile, and sugar in urine.

ANATOMY—1st Year.—DR. BERGIN, *Examiner.*

1. Into how many classes are bones usually divided? Name them and give examples of each.
2. What are muscles; how are they formed; of what do they consist; and how many, and what kinds of muscular tissue are there in the animal body?
3. Enumerate the ligaments of the hip joint, and give their points of attachment.
4. Name the openings connected with the diaphragm and the parts transmitted through these openings.

ANATOMY—2nd Year.—DR. BERGIN, *Examiner.*

1. Describe fully the articulation of the spine with the cranium, including the vertebræ as well as the ligaments.
2. How many kinds of blood vessels are there? Name and describe them briefly.
3. Give the relations of the ulnar artery from its commencement to its termination.
4. Name the muscles of the anterior thoracic region and the nerves that supply them.

ANATOMY—3rd Year.—DR. BERGIN, *Examiner.*

1. Name the tunics and humours of the eye, also the vessels and nerves distributed to it.
2. Describe fully the par vagum ; its composition or divisions ; its origin ; its course and relations ; its branches, and the organs it supplies.
3. Describe the stomach ; its situation, structure, shape, size and weight, and how and by what it is held in its place.

ANATOMY, SURGICAL.—DR. BERGIN, *Examiner.*

1. What bones enter the knee joint? How are its articular surfaces covered and how connected? Whence are the vessels and nerves that supply it derived? What are its actions, and how and by what means are they performed?
2. Where does the internal carotid artery commence? where terminate? Describe its divisions, its relations in such division, its branches, and the peculiarities and irregularities to which it is subject.
3. Name the coverings of direct inguinal hernia.
4. In the operation for median lithotomy, what parts must of necessity be divided?

MICROSCOPIC ANATOMY.—J. W. McLAUGHLIN, *Examiner.*

1. Classify the epithelia of the human system according to their microscopic appearances, and state where each variety is found.
2. Give the minute anatomy of the cortical portion of the kidney.
3. Give the microscopic structure of bone.
4. Give the microscopic structure of voluntary muscle.

MEDICAL JURISPRUDENCE.—GEORGE LOGAN, M.D., *Examiner.*

1. State the appearances and conditions to be observed when called to a case of recent death from suspected poisoning.
2. How soon after death does decomposition begin? Give the order of its occurrence, with the conditions favouring and retarding the process.
3. State how you distinguish human blood corpuscles from that of animals.
4. What is the medico-legal value of the appearance, direction, and extent of bodily wounds from violence?
5. Describe the hydrostatic test, and define its medico-legal value in the detection of crime.

QUESTIONS ON BOTANY.—FIFE FOWLER, M.D., *Examiner.*

1. How do vegetable cells grow, multiply and become transformed?
2. How do spores differ from seeds?
3. What are stomata? Where are they found? What is their function?
4. Describe the component parts of the stamens, pistil, and mature ovary as found in the common garden bean.
5. How would you distinguish exogenous from endogenous plants?
6. How would you proceed with the analysis of a plant to determine what order it belongs to?
7. Give some of the chief characteristics of the following orders of plants—viz., compositæ, cruciferae, labiatae: and mention some plants used in medicine which belong to these orders.

OPERATIVE SURGERY.—J. W. McLAUGHLIN, *Examiner.*

1. In fracture of the femur at its lower third, what displacement is liable to occur, and by what agency produced? Treat the fracture.
2. Give the treatment of compound comminuted fracture of the tibia, with single fracture of the fibula.
3. Name the dislocations of the humerus, and give the symptoms and treatment of the one of most frequent occurrence.
4. What circumstances would indicate lithotomy in preference to lithotrity, and describe the operation.
5. Under what circumstances should the bladder be punctured, and how is the operation performed?
6. Diagnose and treat hydrocele of the tunica vaginalis testis.
7. Give the operative treatment for irreducible-oblique inguinal hernia.

SURGERY OTHER THAN OPERATIVE.—J. W. McLAUGHLIN, *Examiner.*

1. Explain the processes by which repair of wounds is accomplished.
2. Name the causes which retard or prevent repair.
3. Give the causes, symptoms, prognosis, and treatment of psoas abscess.
4. What are the pathological conditions, symptoms, and treatment of phlebitis?
5. Give the causes, symptoms, and treatment of retention of urine.
6. What are the symptoms and treatment of acute synovitis of the knee joint?
7. Describe a femoral hernia, and give its treatment.

PRACTICE OF MEDICINE, ETC.—FIFE FOWLER, M.D., *Examiner.*

1. Give the meaning of the following words and terms: anæmia, leucocythæmia, chlorosis, pyæmia, septicæmia, marasmus, thrombosis, œdema, idiopathic, symptomatic, hypostatic, congestion, subjective symptoms, objective symptoms.
2. What are the chief causes of fatty degeneration? Give a short account of this pathological process, as it occurs in muscular fibre.

3. (*Case.*)—A man aged thirty complains of *cough, dyspnoea, a feeling of tightness across the upper part of the abdomen, and general weakness.* On examination, the cardiac dulness is not found to be increased, the apex beats feebly between the fifth and sixth ribs, a systolic bellows murmur is heard over the apex, it is very faintly heard at the base. Pulse 100, soft and small, considerable dyspnoea and cough *sputa tinged with blood, sibilant and crepitating rales heard over both lungs, but there is no dullness or increase of vocal resonance, the general surface is slightly jaundiced, and there is occasional vomiting; there is some œdema, which in a few days increases, and fluid accumulates in the abdomen: soon there is found dullness on percussion on right side as high as the scapula, and increased vocal resonance, the dyspnoea increases and mouthfuls of florid blood are spit up; in a few days after, he can lie only on the left side, which is found to be quite dull on percussion, with absence of respiration: death soon results.* Point out the significance of the symptoms and physical signs, give the appropriate treatment, and state what morbid conditions you would expect to find on making a *post-mortem* examination.

4. Give and diagnose the morbid conditions which produce vomiting.

5. On what does the dropsy depend which is apt to follow scarlatina? What treatment would you adopt to prevent its occurrence? In what ways may this dropsy prove fatal? What steps would you take to prevent a fatal termination?

6. How would you recognise and treat a case of diphtheria occurring in the throat?

TOXICOLOGY.—GEORGE LOGAN, M.D., *Examiner.*

1. Give the difference between corrosive and irritant poisons, and name two or more of each kind.

2. State the causes and parts of the body which may favour or retard the absorption of poisons.

3. Give the symptoms, treatment, and ordinary tests in poisoning by belladonna.

4. How would you distinguish cholera from poisoning by tartar emetic?

PHYSIOLOGY—1st Year.—J. E. KENNEDY, M.D., *Examiner.*

1. What are the peculiarities of cartilage.

2. What is meant by the terms (a) residual air; (b) supplemental air; (c) breathing or tidal air; (d) complementary air?

3. Describe the arrangement of the capillaries of the air cells of the human lungs.

4. State the pulse rate of (a) new born infant; (b) child of third year. Also within the limits of ordinary health, what are the chief causes of variations in the pulse rate in the adult?

5. What glands secrete the saliva? Give (a) composition of secretion; (b) probable uses in the process of digestion.

6. Name the ductless glands.

PHYSIOLOGY—2nd Year.—J. E. KENNEDY, M.D., *Examiner.*

1. Describe the air cells of the human lung.

2. How are bones developed and how nourished?

3. What are the natural methods for reduction of temperature?

4. Name (a) the constituents of healthy urine; (b) the quantity voided in twenty-four hours; (c) the specific gravity.

5. Name the coats and structure of the arteries.

6. What is the structure of the pons varolii.

MATERIA MEDICA AND THERAPEUTICS.—H. H. WRIGHT, M.D., *Examiner.*

1. Give of each sample enclosed (in envelope) the official name, therapeutic properties and doses, the active principles and doses, and official preparations. (The samples enclosed were: a nutgall, buchu leaves, some santonica seeds, a slice of a colchicum corn, and a piece of socotrine aloes.)

2. Give the official name of cod-liver oil; its commercial history; its composition; its physiological effects; its therapeutics; and its mode of administration.

3. Give rule for apportioning doses to ages, with an example of a hydragogue cathartic at eight years; and a tonic mixture at sixteen years, and an active emetic at one year.

4. How do you classify the so-called "mineral waters?" Give the therapeutic properties of each class.

5. Mention the various modes by means of which medicinal substances enter the organization, with an example of each.

SANITARY SCIENCE.—H. H. WRIGHT, M.D., *Examiner.*

1. Describe water, and give the usual sources of its supply.

2. What impurities are most probably present in water from each of these separate sources?

3. What quantity is supposed to be sufficient for a healthy adult daily? In what form or forms is it supplied to him?

4. Give a detailed account of means for purifying it.

5. Enumerate and briefly describe the steps you would advise on the occurrence of an epidemic in a Canadian village.

6. What is the ordinary mortality average annually per 1,000 in the principal cities of Ontario? At what periods of life is it greatest, from what diseases, and from disease or disorders of what particular organs?

MIDWIFERY OTHER THAN OPERATIVE, ETC.

1. Why in the early stage of what is called a natural labour, is the character of the presentation more obscure than in less favourable cases?

2. State your diagnosis between a presentation of the hand, or arm, and that of the foot, knee or hip, and the proper management of each.
3. In retarded delivery of the head, in a footling case, what benefit would you expect to derive from depressing the chin of the child down towards its breast?
4. Which form of puerperal convulsions do you regard as the most dangerous? State your treatment of such cases, also why it is important that you should, if possible, ascertain the character of the urinary secretion, and the general health of all women by whom you may be engaged for obstetric attendance.
5. Give the symptoms of the several stages of acute hydrocephalus in children.
6. State your diagnosis between small-pox and measles, or scarlatina, and the respective dangers of each, with the periods of their incidence.

OPERATIVE MIDWIFERY.—JOSEPH WORKMAN, M.D., *Examiner.*

1. Describe the conditions of a labour which you may regard as not only warranting, but also as demanding the employment of the forceps; and state why it is that forceps delivery is least harmful where it is least required.
2. What precautions should be taken before introduction of the forceps, and what in the introduction? Why should you use traction only during pains, and what should be the direction given to the handles in the progression downwards of the head, and in its final emergence?
3. A delivery by podalic version, why is it important that particular attention be given to the direction of the feet of the child? State under what circumstances it may be dangerous, or impossible, to change the direction taken by the feet.
4. Describe the process of craniotomy, and state the circumstances which render this alternative imperative.
5. In which sort of labours—the finally very slow, or the very rapid—is laceration of the perineum most likely? State the precautions to be taken to avert this serious accident.
6. In cases of retarded expulsion of the placenta, how will you ascertain that the delay arises from simple detention by the contracting uterus, and not from abnormal adhesion?

Original Communications.

ALBUMINURIA IN PREGNANCY.

BY J. A. MULLIN, M.D.

President, Hamilton Medical and Surgical Society.

Having some notes of cases where albuminuria took place in connection with pregnancy, it may be of interest to bring them before this Society. The first case occurred in 1868. Before this, I had been in practice about seven years, and had attended a good many cases of midwifery without seeing any patient suffering from this complication. When I say the first case, I refer to the first in which convulsions took place, for it is very probable that in many cases the urine was albuminous, as œdema of the face and extremities is frequently noticed in cases, although convulsions do not occur. Rosenstein states that convulsions take place in but one-fourth of all cases of nephritis. It is probable that where œdema of the face and extremities is present, the urine is albuminous, but I have not verified this, for in practice we do not have an opportunity to examine the urine in many cases, for the most part, only in those where important symptoms arise.

I find by a reference to Churchill that in 103,537 cases of labour there were 172 cases of

convulsions, or about one in 602 cases. The proportion seen by different practitioners varies greatly. Dr. Churchill notes two cases in 600 labours; Dr. Granville, one case in 640 labours; Dr. Bland, two cases in 1,897 labours; Mad. Boivin, 19 cases in 20,357 labours, or about one in a thousand.

Braun states that in Vienna 44 cases of convulsions occurred in 24,000 labours, and Bartels, Ziemssen's Cyclopædia, concludes that nephritis occurs in the proportion of one case in 136 cases of pregnancy.

No. 1.—This patient, aged 35, had been very ill in a pregnancy which was ended by a miscarriage about two years before. She then resided in one of the Eastern States: I could learn very little of this illness; she had told her friends that the physician in attendance had predicted that if she became pregnant again it would be fatal to her. I was called to her bedside before seven a.m., at about the sixth month of pregnancy, on account of a fit: the spasm had ceased before I arrived, and she was somewhat conscious; I introduced the catheter, and found only a small quantity of urine in the bladder (one ounce). This, on being boiled, was thick with albumen. I waited with her for some time, but as no spasms took place, left her, having recommended means to promote perspiration. Labour pains came on at intervals, and I

was re-called about ten a.m., the second convulsion having taken place a few moments before. Dr. Rosebrugh accompanied me. We gave chloroform, and finding the os dilated, the foot was easily reached and delivery effected in a short time. Convulsive attacks took place from time to time, the fits came on very quickly when the anæsthetic was partly withdrawn; while deeply under its influence, the patient for a time was protected from very severe attacks. In the course of the afternoon, the spasms came on very frequently, and the heart's action growing feeble, the chloroform was withdrawn. Hot air baths were used to promote perspiration and digitalis administered, with hot poultices to loins to restore the action of the kidneys, but without success. Death took place before six the next morning. In this case, there may have been some family predisposition to kidney disease, for a sister has since died from Bright's disease.

No. 2.—This case came under my observation in the spring of 1870: the patient had been married in the autumn of the previous year: at about the fifth month of pregnancy, she complained of some defect of vision and symptoms of debility, that probably depended upon an affection of the kidneys. A physician was consulted, and she was advised to visit her friends in a distant town; while there, a miscarriage occurred, and along with symptoms of debility, there was defective vision, which the physician in attendance informed me depended upon retinitis, and which he said had improved much under the use of the bi-chloride of mercury after the miscarriage. Upon her return to this city, I was consulted, and found that the urine was albuminous. The eyes were examined by Dr. Rosebrugh, of Toronto, who stated that the condition of the retina was such as is often found in patients suffering from uræmia. The albumen in urine diminished in quantity, the patient receiving iron and other tonics, while the defective vision passed away and the health appeared quite restored. She then passed from my observation, as I was absent from the city for seven months. Shortly after the holidays, in the winter of 1870-71, another miscarriage occurred, and again in autumn of 1871. I do not know the time of

pregnancy when each of these took place, nor can I report respecting the condition of urine, but from a correspondence in the symptoms with those of the previous, and a subsequent pregnancy, I infer that these miscarriages had been due to the same cause. The patient afterwards consulted me in the autumn of 1872, as she was suffering from menorrhagia, with some feelings of weight and bearing down in the pelvis. The urine showed a very slight trace of albumen, the general condition improved, also the pelvic symptoms, and towards the end of 1872, she again became pregnant. The urine was examined frequently during the early months, without showing any increase of albumen, the general health being good. About the middle of April, when the patient had advanced a little over four months in pregnancy, she had a chill, apparently from taking cold, there was severe vomiting, with fever; and the urine at once showed a marked increase of albumen. The febrile symptoms passed away, but the increased albumen continued. After being confined to bed about a week, a brownish discharge took place from the vagina: the patient suffered much from headache, and the vision became so indistinct that she could not distinguish the features of friends.

Dr. Macdonald consulted with me, and we concluded that the safety of the patient required the pregnancy to cease. Means were used to dilate the os, and induce uterine action, which resulted in the delivery of a foetus that had evidently been dead for several days. Up to this date the defective vision, headache, and other symptoms of uræmic poisoning had become almost alarming; but the day after the pregnancy ceased the patient began to improve, and in about a fortnight the condition was so favourable that my regular visits ceased. From this date the patient enjoyed moderately good health, though she suffered at times from neuralgia: the urine was examined frequently, but only showed a slight trace of albumen. On May 14th, 1874, a chill occurred, due to sitting in a cold hall, followed by febrile symptoms and a marked increase of albumen in the urine: a few days after, pleurisy of the right side, with appearances of general œdema. One week after the commencement of febrile

attack, convulsions occurred, three times in a day, the urine became more scanty, indications of endocarditis followed, and death took place the fourth day after the convulsive attacks. During the time she had been under my care she had not told me of any illness before her marriage, but when attending in the last illness some of the friends stated that several years before she had suffered from some trouble in the kidneys, due to exposure to cold, but it did not appear that she had been under medical care for it, nor could I learn that any physician had thought her the subject of Bright's disease.

No. 3.—This case was that of a primiparous patient, aged twenty. She had not been under my care, nor had I seen her before. Called to attend in the forenoon of March 18th, 1874; she stated that her health had always been good. The labour proceeded in a natural course until near the end, when a convulsion occurred; I immediately applied the forceps, and delivered the child without difficulty about one p.m. A second convulsion occurred, when the placenta was removed. A full dose of chloral hydrate was given, and the convulsions did not return until the evening of the same day. Some urine was drawn by the catheter and found highly albuminous. Full doses of chloral hydrate were given in the night, and hot applications to excite diaphoresis. On visiting the next day, I learned she had had five convulsive attacks in the night: she was quite conscious at the time of my visit and her appearance did not show that she had passed through so severe an illness. Afterwards the urine was passed in a large quantity and in a few days ceased to give indications of albumen. At the end of the week she was as well as patients usually are at this time. Since that she has been delivered twice, but without any recurrence of convulsions.

No. 4.—I may mention here the case of a patient, aged thirty-nine, who had generally been healthy and had given birth to nine children, these pregnancies attended with no unfavourable symptoms. In her tenth pregnancy, at the end of the seventh month, the urine became bloody, and continued so until the end of the term—the patient was anæmic, but no dropsical symptoms supervened—iron and

quinine given, and the labour took a natural course; soon afterwards the urine became normal. Since that, the health has been very good. She gave birth to her eleventh child in July, 1877, without any recurrence of blood in the urine. I was not able to account for its occurrence in her tenth pregnancy.

No. 5.—In 1875, April 11th, attended Mrs. E—, aged eighteen years, primipara: no illness in course of pregnancy except slight bronchial catarrh. The labour was difficult on account of slow dilatation of the os and a brow presentation: chloroform was given and the forceps used: waited an hour after the labour ended. She received a dose of chlorodyne to allay after-pains, and slept well till four the next morning. Since that, slept now and then for a few minutes.

April 12th.—She appears comfortable, has slight pain over the pubis, lochial discharge sufficient, has passed urine freely since morning. P. 100, skin cool, tongue clean. Ordered a poultice to be applied over the uterus.

Was summoned at half-past three p.m. the same day, the patient having had a fit: on reaching the house, a few minutes before four o'clock, found her conscious, but restless: the urine had passed since morning. The catheter was now used, and half a pint drawn off: this was examined and found albuminous, pulse 140. A few moments after four o'clock, a violent convulsion occurred, chloroform was given, and its influence kept up till ten p.m.: no recurrence of the spasm. Hot bricks were used to induce perspiration, a drop of croton oil given.

On inquiry, it was learned that the patient had suffered since eleven a.m. from pain in the head, though she did not complain of it as severe. She also felt nausea in the afternoon: nausea had occurred frequently during the latter months of pregnancy. After this date, the convulsions did not recur: for several days, the urine was drawn morning and evening with catheter. She suffered from tenderness of uterus, with frequent pulse, restless, and requiring chloral hydrate at night to produce sleep. On the 18th, the following note was taken:—Rested well without chloral, pulse 108, skin cool, no tenderness, urine passed voluntarily,

appetite good, and feels well. Subsequently, chills and fever occurred depending upon pelvic cellulitis, with formation of pus. The urine became normal after the first week.

No. 6.—April 16th, 1876. Mrs. R——, aged forty-three, healthy; had been married eleven years; this the first pregnancy. The labour was somewhat tedious and painful on account of slow dilatation of os uteri. In the last stage, a convulsion occurred, chloroform was at once given, and the delivery completed with forceps: a second fit after the delivery of placenta. The urine was drawn with catheter, and found albuminous. For the first week after the delivery, the catheter was used morning and evening, the quantity was apparently normal, and the albumen disappeared before the end of week. Chloral was given at night the first week and hot applications over the kidneys. The patient made a good recovery, and has since continued quite well.

No. 7.—Mrs. McC——, aged twenty-five; had been married about three years, previous to which the health had not been very robust. For about two years, she was anæmic, but could not be persuaded by her mother to consult a physician. Christmas, 1874, a miscarriage occurred at the fifth month. I saw her at the time and for a day or two, but did not examine the urine, as she was averse to medical treatment. In February, 1876, another miscarriage occurred at about the same period of pregnancy, attended by another physician.

I saw her from time to time, and noticed that her appearance was generally anæmic, but was not asked to prescribe for her.

Early in 1877 I was engaged to attend her in confinement. On the evening of January 28th called to visit the patient and found that the pregnancy had advanced about seven and a half months; she was complaining of severe uterine pains, which had been troubling her, more or less, through the afternoon. There was no dilatation of the os: and after a few doses of chlorodyne, the pains ceased. Upon inquiry, I found that for two days she had suffered from disagreeable feeling in the head, at times dizzy with some impairment of the vision, the urine was scanty and contained a large quantity of albumen. She was directed to re-

main in bed, and upon visiting her the next day, the symptoms had somewhat improved. The head symptoms had passed off, no pains since the night before, the urine more copious. She was advised to remain in bed, and means were taken to promote perspiration by the use of hot air. Digitalis and nitrate of potash were given, and the bowels acted upon with Bitart. potas. and senna.

The urine was examined frequently in the course of the week, and always showed a considerable quantity of albumen. The general condition improved, so that for a few days I did not visit her, but sent medicine as needed.

The evening of the 9th February, I was again asked to see her, and found her suffering from severe pain in the epigastrium, with vomiting. Chlorodyne was again administered, but rejected soon afterwards. I sent also a few doses of paregoric, but they afforded no relief, as the patient vomited frequently, and was also troubled with eructations. About midnight, I was called, as she had been seized with a convulsion. Before my arrival, a second had occurred. I found that uterine action had begun, the os was somewhat dilated, and the dilatation (after the administration of chloroform) was soon completed, so that I was able to apply the forceps and deliver. The child was immature. The placenta soon came away, but as a considerable quantity of blood escaped afterwards, pressure and manipulation of the womb were made, and during this a convulsion occurred about twenty minutes after the birth. After this I remained for two hours: there was no return of the convulsions. The patient continued during the night in a comatose condition. Morph., grain one-third.

February 10th.—P. 76, resp. 18, tongue dry. The bladder was emptied by catheter of only three ounces: very dark, and contained a large quantity of albumen. Temp., 94; skin, moist; patient very drowsy; no return of convulsions. Hot applications to the loins, and nourishment to be given.

February 11th.—Morning—pulse, 108; resp., 16, irregular, tongue clean, moist, skin moist, temp. 96½. The urine passed in small quantity without catheter. Has vomited.

several times in the night a greenish fluid. Evening, P. 96, skin cool, tongue moist.

12th.—P. 84. Passed small quantity of urine. The conjunctiva of right eye injected. Patient more conscious than since delivery.

13th.—P. 114, skin warm, resp. 18, tongue red, somewhat dry, the urine in small quantity. Last evening, had a chill for a few minutes; today, complains of a pain over the womb, which is hard and tender. Opiates given, discharge scanty and offensive.

14th.—P. 120, skin cool, temp. $98\frac{1}{2}$, tongue furred, dry, urine more copious, clear, bowels not moved, pain continues over the uterus, much troubled with eructations and flatulence, but has not vomited, refuses milk, wine ordered.

February 15th.—P. 130, temp. normal, loch. discharge slight, tenderness of uterus continues, bowels moved, urine in good quantity, tongue moist.

February 16th.—From this date the patient's strength declined: frequent vomiting, and on the 18th the patient became comatose and died. No *post mortem*. It was impossible to get the urine for examination after February 10th.

No. 8.—Mrs. —, aged twenty-four, said to have been quite well until the evening of July 1st, 1874, when uterine pains came on after a ride of six miles in a buggy—a slight discharge as if unwell—she had just completed the seventh month; had been nervous, easily excited, and several attacks apparently hysterical had occurred. Her eldest sister suffered after her second confinement from convulsions, probably uræmic. Attendance from eight a.m., July 2nd, till half-past one p.m., when child born apparently at the seventh month. The lochial discharge was free the first six hours, and I removed some clots from the vagina in the evening.

The next morning, (July 3rd) visited at eleven: she had been restless and slept none; in the last hour, had several attacks which were thought to be fits. I found her suffering from inability to take in a full breath: she told me she would choke: the condition appeared hysterical. Tr. Valerian and Pot. Bromid. ordered. In the afternoon, gave some paregoric and aromatic spirits of ammonia to relieve her

of pain in the epigastrium. At six p.m., visited her, and learned that a fit had occurred. She spoke to me intelligently, and said she was afraid of choking. About eight, and again at ten p.m., saw her with Dr. Woolverton. Just before each visit, she had had a fit. The friends said she had been delirious, but she spoke to us intelligently. The lochial discharge had been slight during the day, bowels not moved, urine passed voluntarily in the morning and drawn with catheter in the evening at ten p.m. The quantity seemed normal—that drawn by the catheter was found to contain albumen. Two doses of chloral hydrate, fifteen grains each, ordered at an interval of three hours.

July 4th.—Visited at ten a.m. Had spent a restless night, slept none, had several nervous attacks, and had now become insensible. A homœopathic practitioner was called in.

Learned at last visit that the feet had been swollen during the pregnancy, and the face to a slight degree. I did not observe this. She made a good recovery. This case was probably one of eclampsia, though until the evening of July 3rd, I thought from the account given of the fits, and the condition of the patient at my visits, that the condition was hysterical. The labour at the seventh month was nature's method of meeting the condition.

The following case is one where in several succeeding pregnancies the uræmic condition has occurred:—

No. 9.—Mrs. A. —, aged 37, has given birth to four children at full term, the first at the age of 25, the last in 1872. In two confinements I attended, her labours were difficult, but, so far as is known, she did not present, in any of these pregnancies, any indications of albumen in the urine. She had no illness after the birth of the child in January, 1872—lactation was continued thirteen months. In her fifth pregnancy, at about the middle of the fourth month, œdema of the face and extremities were noticed; two weeks afterwards, the 1st of July, 1873, she consulted me: there was marked œdema of the face and extremities, and albumen was found in the urine. On the 28th of the same month, a miscarriage occurred, the œdema soon passed away, and the albumen disappeared from the urine. Health regained.

rapidly. In January, 1875, she gave birth to a dead fœtus at the seventh month; the fœtal movements had not been felt for two months; there was œdema of the face one month before the miscarriage, but I had no opportunity to examine the urine. She gained strength, and my attendance ceased in a week. I had no occasion to see her again professionally until the end of December, 1876. At this time, in the ninth month of pregnancy, the feet and legs were very much swollen—some œdema of eyelids. She did not complain of pain, and continued to attend to household duties, although recommended to rest as much as possible in recumbent position. The urine was loaded with albumen—the bowels costive. Ordered ʒss. pot. bitart., with a teaspoonful of pulv. glycyrrh. co. (Pruss.), every evening.

January 10th, 1877.—Did not see the patient again until to-day. Notified by a neighbour at 8 a.m., that she had been found insensible a short time previous. Last evening I received a message that she had a cramp in the stomach. As I could not visit her at once, I sent a few doses of chlorodyne, and requested them to send word if symptoms of labour appeared. On visiting her, I found that after taking the chlorodyne (one dose) she had rested well and had very little pain. She is conscious, and speaks to me of her condition, but soon lapses into sleep. Occasional pains occurred, dilating the os slightly; the tongue was wounded, as if injured by the teeth, in a fit which probably occurred about 7.30 a.m. Pulse natural, skin cool, drowsiness continuing, but without convulsions, the pains coming on at short intervals. About 11.30 a.m., Dr. Malloch arrived, and after chloroform was administered, the os was dilated with the fingers so that the medium size of Barnes' dilators could be introduced, and soon afterwards the largest size. By half-past twelve the os was dilated to admit the hand; the head was pressed against the os, but uterine action did not appear sufficient to advance it. Hunter's forceps were applied, but slipped over the head, although closely locked, the head being very small. The right hand was then introduced and the feet brought down. Delivery was completed at 1 p.m. The child at first did not

breathe, but after a short time the efforts to resuscitate made by Dr. Malloch, were successful. The uterus contracted well, and no convulsion took place, except the one that probably occurred before my arrival. The child died three days after birth, having been very feeble and apparently immature. I have no notes after this date. It will be sufficient to state that the patient had not the benefit of good nursing, and for several days she suffered with symptoms of metritis, from which, however, she recovered. My attendance ceased after the 20th January. The œdema passed away rapidly, and the albumen soon disappeared from the urine. The patient gained her health quickly, menstruation occurring regularly for several months; the urine, examined at different times, showed no indications of disease. The regular monthly period took place in the middle of July, 1877, after which the usual symptoms indicative of pregnancy which proceeded in normal course. The urine was examined at different times, but no appearance of albumen, until the end of January, when the patient, who had not been feeling as well as usual for a fortnight, came to my office. The urine was found albuminous, the quantity large, specific gravity low, 1008. Iron was given, means used to promote diaphoresis, and rest enjoined. During the second week of February the symptoms indicative of uræmia more marked, the general œdema increasing, the legs and thighs very much swollen.

February 17th.—Complains of very severe headache, urine sp. gr., 1004, loaded with albumen, œdema very great, has not felt the fœtal movements for several days; vaginal examination showed the uterus low down, the os partly open;—it was dilated this afternoon with the finger. The patient was then left for several hours; summoned at 2 a.m., February 18th, as she complained very much of severe headache, with some twitching of the muscles, and the os was dilated so that the smallest size of Barnes' dilators was introduced. Gradual dilatation was then continued for an hour, when Dr. Malloch arrived and administered chloroform. I was then able to reach a foot and turn; delivery was soon completed; child had been dead some time. Urine in

evening drawn by catheter, specific gravity, 1004.

19th. Urine drawn by catheter, specific gravity, 1008; albumen less.

20th.—Urine, 1012; very little albumen.

The patient recovered health rapidly, the œdema passed away, and in a fortnight she was able to attend to household duties.

March 29th.—Urine slightly albuminous, specific gravity, 1018; health apparently good.

No. 10.—Two days before the delivery in the case above noted, I was called to attend a primipara, aged 21, who had reached the end of the eighth month of pregnancy. She had had a fall about one week before; slight œdema of eyelids noted. The labour progressed favourably, but in the last stage as the pains were severe and perineum somewhat rigid, chloroform administered for half an hour. While tying the navel string, the patient had a convulsion. The chloroform was administered for an hour, afterwards half a grain of morphine by subcut. injection. No return of convulsions. Urine drawn by catheter, and found albuminous. Six hours after labour, a large quantity of urine passed voluntarily. For a week slight traces of albumen were found in the urine; at the end of the second week the albumen disappeared, and the health has since been good.

Six of these cases had convulsions at the time of delivery; in three, the birth took place before the full time, in three, when the full period of pregnancy was completed. In two cases, convulsions occurred the day after delivery; and in two, there were no puerperal convulsions, one of these being No. 4, where blood was constantly in the urine the last two months of pregnancy; in the other, fatal uræmic convulsions occurred more than a year after the last pregnancy. All of the cases, where convulsions occurred at the full time, recovered; in one, the recovery took place under the care of my successor: possibly, the result would have been not less favourable had this patient continued under my care. In the two cases which ended fatally, the labours took place before the full time; one died within twenty-four hours of the eclamptic seizure, the other, ten days afterwards from metritis. In

the fatal cases, it is somewhat probable that there had existed disease of the kidney, though in none were marked symptoms of kidney disease shown except in connection with pregnancy. The dependence of this condition upon pregnancy is certain, though in what manner pregnancy causes it is not so clear. It has been said that the pressure of the enlarging uterus on the renal veins gives rise to obstruction in the circulation of the kidney. The more frequent occurrence in the later months, and in first pregnancies where the abdominal walls are less yielding, favour this view; but it may occur in the early months of pregnancy, and it has been observed in women whose abdomens were pendulous. In both of these classes, there could be no pressure, or very little, on the renal veins. It is to be noted that although this complication is more frequent in first pregnancies, cases are reported where women have not suffered from it in the earlier, but in the later pregnancies. In case No. 9, four pregnancies passed without the complication, and then in four successive pregnancies albumen was found in the urine. In the article in Ziemssen's Cyclopædia, a case is referred to where the patient escaped in sixteen pregnancies, and suffered from it in the seventeenth. Bartels points out that the position of the kidneys and renal veins, in relation to the uterus, is such as to render them but little liable to pressure, a considerable space intervening, which is filled by the intestines. If dependent upon pressure of the enlarged womb, the left kidney, it might be expected, would be more frequently affected than the right, or affected to a greater degree, but it has been found that both kidneys are equally diseased.

Again, if pressure were the cause, it might be expected that in cases where the abdomen is distended with ovarian and other tumours, the same results would be seen. Such have not been observed, though this may be due to the number of such cases being comparatively small. The condition has been attributed to the composition of the blood in pregnancy, rich in fibrin and white blood corpuscles, poor in red corpuscles and albumen; but while the character of blood may not differ much in all

pregnancies, why should it lead to this condition in a very small number.

By some it has been attributed to a cachexia, but it attacks the most blooming and robust. In three of the cases I have noted, disease of the kidney may have existed before pregnancy, but the others, in general health, compared favourably with the majority of pregnant women.

A very interesting paper is published in the *CANADIAN JOURNAL OF MEDICAL SCIENCE*, January, 1877, by Dr. Martin, of Kings Co. Medical Society, N. Y., in which notes are given of a case where the condition occurred in the very early months of pregnancy, and where the kidneys rapidly reverted to a normal state after the pregnancies were terminated at early periods. The writer refers the condition to a nervous relation between the uterus and the kidneys, whereby the nutrition of the latter is changed. Certainly, there are various changes of nutrition in parts distant from the uterus dependent upon pregnancy; but here we have a change of the nutrition of the kidney unlike those elsewhere observed which results in the development of parenchymatous nephritis. The appearances after death are said to correspond "exactly with those which are presented by acute renal inflammation due to other causes, as scarlatinal nephritis that has run a protracted course. The kidneys are larger and heavier than normal from thickening of the cortical substance. The cortex is anæmic, of a pale yellowish colour. What resemblance is there here to the very vascular dark-coloured and usually firm and compact kidneys that we find when venous stasis has existed?" is asked by Bartels, in Ziemssen's *Cyclopædia*.

The pathological conditions, however, rapidly pass away in most cases after delivery. This is not always the case; in No. 9, the condition quickly ceased after former pregnancies: the urine, examined six weeks after the last delivery, still showed some albumen. Bartels notes the case of a young woman who, in her first confinement, Nov. 18th, 1870, had convulsions: the albumen disappeared before the end of the month. Her second pregnancy passed without difficulty. In her third pregnancy, she suffered

from ague; and in the fifth month, was attacked with convulsions and delivered on the 29th October, 1873. Consciousness did not return till the 4th of November. The quantity of albumen was very large, and though much reduced in November, did not disappear till February, 1874. The treatment of this condition in pregnancy may, with profit, be discussed by the members of this Society. Bleeding may sometimes be useful. Bartels says, "The first case of eclampsia which I saw, occurred in the person of a primipara with renal disease, and the late Michælis, who was then my preceptor, made me bleed her freely. The patient, who had previously recovered from one attack of convulsions only to fall into another, had only one severe convulsion after the venesection." In speaking with those who have frequently bled, I have not learned that bleeding is generally so efficacious in arresting the convulsive attacks. In none of these cases did it seem advisable to bleed; as regards six (or seven, including case No. 4), the result could not have been better. I notice that of six cases reported by Dr. James Ross, of Toronto, in the February number of the *CANADIAN JOURNAL OF MEDICAL SCIENCE*, only one was bled:—this patient was strong and plethoric, and had no œdema of extremities; the others appear to have been pale, with œdema of extremities. The condition of urine is not noted. All recovered. As regards the patients Nos. 1 and 7, where the termination was fatal, it is doubtful whether bleeding would have led to a different result. Bartels states that in every case where complete suppression of urine took place, the termination was fatal; and this, even though after prolonged suppression, small quantities of bloody urine passed. In these fatal cases, the suppression was almost complete, and their history does not point to a sudden congestion of the kidney such as blood-letting might relieve, but rather to a condition which was the result of changes that had probably existed for several years, greatly aggravated by each succeeding pregnancy. In these days, we are not very familiar with the results of blood-letting, but I hardly think that its most sanguine supporters would expect relief to follow from its use in

cases where the condition had existed so long. If pregnancy continues till the urine is almost suppressed, it is probable that the case will end fatally. It would seem advisable, when the symptoms of nephritis are observed, to watch the course of the pregnancy, and to anticipate a fatal suppression by inducing premature labour.

THE INFLUENCE OF THE WEATHER ON HEALTH.*

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The study of physiological meteorology, which has for its object the investigation of the connection between atmospheric conditions and the *health* of such organisms, animal and vegetable, as are subject to these conditions, is a most important one, especially as an examination of the influence of the weather shows its changes to be associated in a remarkable manner with the varying conditions of health. Sudden changes of temperature, long periods of drought, etc., will prove this to the satisfaction of the most superficial observer. Many books have been written and a number of ideas advanced, but the subject has never been attacked in a systematic or scientific manner, on account of the difficulty of obtaining sufficiently reliable data.

The intimate relations between weather and *mortality* have been conclusively shown, and by none more ably than by Mr. Buchan and Dr. Arthur Mitchell. These gentlemen compared the reports on the weather and the vital statistics of London, England, for a period of thirty years,† and the results show that *at least for one city* the mortality from nearly all diseases is much affected by the atmospheric conditions. In the discussion, the year is divided into weeks and into six periods, the characteristic features of each period respectively being, dampness and cold, cold, dryness and cold, dryness and warmth, heat, dampness and warmth.

In the damp and cold period (from the 4th week in October to the 3rd week in December),

no disease shows a rapid diminution in the death rate. It is, however, to be noted that nearly all the diseases which show a relatively low mortality at this season, are either bowel complaints or diseases connected with the nervous system, the number of deaths from the latter cause, however, begin to show an increase. The period characterized by great and protracted cold (from 4th week in December to 3rd week in February) shows a larger death rate than that which occurs at any other season; being the time when the largest number of diseases show either an excessive mortality or reach the maximum for the year. The largest excess occurs among the diseases of the respiratory organs. In the dry and cold period (from 4th week in February to 2nd week in April), the diseases connected with the nervous system show the death rate which is most in excess. Bowel complaints have the minimum mortality in the dry and warm period (from 3rd week in April to 4th week in June), but begin to rise at the close. The latter half of this period is the healthiest season of all the year, particularly as regards infants. It should be noticed that at this time thunder storms begin to occur with greater frequency. In the period characterized by heat (from 5th week in June to 4th week in August), the most marked feature is the large accession to the death rate from diseases of the abdominal organs, which attain their annual maximum at this time. The last period, damp and warm (from 1st week in September to 3rd week in October), is a very healthy one. In September, no disease but scarlatina shows a rapidly increasing death rate, and this is the only disease which reaches its maximum in October.

These results, however, should by no means be taken as representing a curve, the principal features of which would be the same in all places. In fact, investigations show that in different places deaths from particular diseases exhibit very different degrees of sensitiveness to weather. There are, however, many features which will be found well marked in all investigations of this character. As the death rate among children forms such a large percentage of the whole, so it influences the formation of the general curve. Thus it will

* Being an abstract of a paper read before the Canadian Institute, April 29th, 1878.

† *Journal of Scottish Meteorological Society for July, 1875.*

be found that the largest number of deaths occur usually in the hottest portion of the year, and the minimum during the damp and warm season, being that in which the fall of rain occurs most frequently. In a comparison of the weather and mortality in Toronto for 1876,* although the data are imperfect, the death rate being for only one year, the results bear out Mr. Buchan's conclusions.

Dr. J. W. Tripe has made some valuable observations on the influence of the change of temperature on mortality; and he, with many other writers, comes to the conclusion that very hot and very cold weather induce an increase in the number of cases of disease and of deaths, and that a temperature between 55° and 65° is most beneficial to health in England. A cold wet summer always coincides with a less amount of sickness and fewer deaths than a hot dry summer. He says "the rate of deaths in weeks having a mean temperature of less than 35° was nearly 45 per cent. greater than in weeks having a temperature of 60°-65°; and in weeks having a mean temperature above 65°, the average rate of death was about 30 per cent. more than in weeks having a mean ranging between 60° and 65°." There may, perhaps, be a certain temperature for each disease, during the prevalence of which the disease is at its minimum. This appears to be the case with diarrhoea and other diseases of the same class, for the mortality from this cause, with the continuance of the mean above 65°, is at least twenty times as great as at 40°-50°. The deaths from smallpox begin to decrease as soon as the daily mean reaches 62° and has continued above that for a short time. This disease does not increase in fatality until the temperature falls somewhat below that. Whooping-cough appears to act in a similar manner; but scarlatina is exactly the reverse.

A cold wind abstracts heat from the body, and in proportion to its velocity. Some interesting effects of the exposure of the body to cold have been shown by Dr. John C. Draper, of New York,† by means of a bathing experi-

ment, and the results are, that an exposure of the body for one hour to water of a temperature of about 74 degrees, causes increased respiration and a reduction of the heart's action. He states "There is also a tendency to congestion of various internal organs, especially of the lungs, and the establishment of a pulse-respiration-ratio similar to that of pneumonia."

A hot dry wind increases evaporation, and thus lowers the temperature of the body.

It often occurs that an increase in the number of deaths is put down to defective sanitary arrangements, when, in all probability, it is simply an effect of weather. One curious example of this has been shown. In the beginning of May, in 1867, and to the middle of June, there was a great difference between the temperature of Edinburgh and that of London, the latter place being much warmer; and it so happens that at this time attention was extensively drawn in the newspapers to the high rate of mortality in Edinburgh and the low mortality in London. This difference was generally attributed to defective sanitary arrangements in Edinburgh, and the point was largely discussed. So great a difference of temperature, however, could scarcely exist without influencing the death rate, which for the six weeks rose in Edinburgh 4 per cent. above, and fell in London 18·3 per cent. below, the weekly mean for the whole period of six months.

In the relation of temperature to disease, it almost always follows that when the curve of temperature is above the mean, the curve of deaths is below. This is more especially the case in the winter months, and is most marked when the deaths which occur from diseases of the organs of respiration are separated from the rest.

It is probable, however, that the large majority of diseases will show a more intimate connection with the amount of moisture present in the atmosphere, than with any of the other meteorological elements. Dr. Parkes says "The most agreeable amount of humidity to most healthy people is when the relative humidity is between 70 and 80 per cent." (100 being complete saturation). On the amount of moisture present in the atmosphere and on the cleansing

* See Appendix to Report of Registrar-General for Ontario, 1876.

† American Journal of Science and Art. Vol. IV., page 445.

power of rain, health must, to a very large extent, depend.

Rheumatic and neuralgic diseases are curiously affected by the weather. Around the centre of every storm, there is usually an area in which rain is falling. This extends about 500 or 600 miles in advance of the storm. Outside of this, there is another belt of about 150 miles in width, called the "neuralgic belt." One proof of this is given by Dr. Weir Mitchell, of Philadelphia,* who describes the experience of Captain Catlin, U. S. A., whose leg was amputated below the knee, and who suffered from neuralgic pains in the foot and toes on the advance of a storm. It is a question whether this is due to the excess of moisture in the atmosphere or to lessened pressure. In those who come suddenly out of the increased air-pressure of diving-bells or sub-aqueous chambers, there is said to be a liability to pains in the limbs, and Dr. B. W. Richardson seems to think the experiment thus made valuable, as illustrating the influence of lessened pressure. Dr. Parkes speaks of this influence as shown by balloon ascensions, being quickened pulse and respiration. M. Paul Bert, in some experiments made in a chamber from which the air was partially exhausted, shows that this is due, not so much to lessened pressure, as to a decrease in the amount of oxygen imbibed, and proves that by increasing the amount of oxygen, the pulse resumes its normal condition.

Health is thought to depend upon the amount of ozone in the atmosphere; but as we have no data to go upon in this respect, on account of the very imperfect means for testing the amount thoroughly, no deductions of any value can be made. It is supposed that the presence of ozone is greater with high barometer, temperature, and dew-point; and less when the air is dry, or completely saturated.

The amount of sunlight must influence health, but, unfortunately, the importance of recording the number of hours of its duration appears not to have been sufficiently recognised, as but few registers are kept for that purpose.

The connection between weather and mortality will probably have been proved to the

satisfaction of every one. It is not enough, however, that we should know how the weather has affected a person who is dead, we should be able to show how the *progress* of the disease is influenced by it. The returns of deaths only show the ravages caused by epidemics. They can never furnish us with such immediate notice of their origin as to enable us to take precautionary measures. This can only be done by a proper system of registration of health, in order to show the prevalence of disease. It is by no means improbable that some diseases might be prevented altogether, or at least be stopped before they reach their dangerous points, by this means, and by determining what the causes are which most influence its changes. It is well known that a large number of diseases originate through the introduction into the system of solid matter or germs which are propagated through the atmosphere. Dr. Angus Smith says "The large amount of solid matter in specimens of rain sent from Glasgow led me to connect it with the great mortality of that town." If then diseases are contracted in this matter, we should endeavour to determine what are the atmospheric conditions most favourable for the propagation of these germs, and, if there are different kinds of germs, whether they require special states of the atmosphere. There is no doubt that we shall be nearer the solution of this question when the influence of the weather on health has been definitely settled. No country is so advantageously situated as Canada for thoroughly investigating this subject. If the connection between weather and health proves to be so intimate as we are led to expect, we shall be able to foretell the changes in the health of the people, and give warnings of approaching epidemics as we now predict coming weather.

Apart from the solution of this question, a proper system of registration of health is highly important, and must prove beneficial; and it is to be hoped that medical men will co-operate with this end in view. While so much trouble is taken to obtain an accurate record of the rate of mortality, it seems curious that no step has been taken in this direction. This is properly the duty of the Government, for, as the late Prof. Henry says in his report on the Smithsonian Institute for 1865, the administration of the Government should not be limited in its operations merely to objects of instant or immediate utility, but, with a wise prevision of the future, it should withhold its assistance from no enterprise which has for its end to advance the well-being of humanity.

* *American Journal of the Medical Sciences*, April, 1877.

Translations.

From *Gazette des Hôpitaux*.

SURGEONS' DUTY IN CASE OF MUTILATION OF HAND.

A-propos of a little operation, which I am about to do on a young patient who entered our wards three months ago with a crushed hand, I must once more insist upon the course which a surgeon ought to pursue in wounds of the hand. Whenever you shall have to treat a patient suffering from any crushing of the hand, adopt it as an absolute rule to excise nothing and to trim nothing with a knife. In those cases the surgeon ought only to think of warding off and controlling primary complications; but he should leave to nature the care of saving whatever she can save; she will preserve more than the surgeon, and will always waste less. We do not sufficiently clearly conceive how much of the lacerated, and on the first day condemned, tissues may resume their vitality and be repaired. Allow nature then to act. Wait. Later, after weeks or even months, when cicatrization shall have occurred, then only should the surgeon interfere and trim the wound in such a way as to procure for the patient the fullest use of the limb.

From *Lyon Médical*.

ON THE MILK DIET IN CHRONIC PLEURISY.

BY DR. CURCI.

Before resorting to the milk diet, Dr. Curci had submitted his patient to the use of a remedy, still little employed in pleurisy, jaborandi, which he had administered in infusion in the dose of a drachm per day. The jaborandi, in this case, had been perfectly tolerated, and had produced its usual physiological effects, abundant salivation and diaphoresis; but the pleuritic effusion was not modified in the least. Digitalis, squills, and iodide of potash had given no better results; and it was only after a series of fruitless endeavours that Dr. Curci had recourse to the milk diet. Patients have some difficulty in confining themselves to this regimen, they soon acquire a disgust for milk when all other aliments are denied them. But there is no medication

which has a more rapid or more certain effect upon the urinary secretion. On the fourth day of the milk diet, the diuresis had considerably augmented, and the pleuritic effusion began to diminish, and at the end of twenty days, the cure was complete.—*Sperimentale*.

From *Le Progrès Médical*.

At the Session of the Academy of Medicine on 19th Dec., 1876, M. Laboulbène communicated an extremely interesting case of exfoliation of the stomachal and œsophageal mucous membrane following poisoning by sulphuric acid of 66°. Having been employed for a long time in a chemical factory, he immediately had recourse to an antidote, and swallowed, five minutes after the accident, a large quantity of milk. Copious emesis occurred immediately, and only then the patient, who had not previously experienced any pain, felt a very acute sensation of burning in the throat and back of the mouth. More than a week later, the patient brought up, in an attempt to vomit, a shred of membrane seven to eight centimetres long, black and pulpy, which M. Laboulbène thought must be the œsophageal mucous membrane. Some time afterwards, the patient threw up a new membrane as large as the two hands, and which had all the external characteristics of the stomachal mucous membrane. Examined under the microscope, this membrane seemed to be composed of a skin of fibrous and elastic tissue in the middle of which vessels, filled with carbonised blood, wound, but no trace of glands was found. For some time now, the patient has ingested a little milk, eggs, and a little bread dipped in gravy, but his general state is bad and inspires some apprehension.

MM. Gubler and Colin did not appear to be satisfied that the membrane presented by M. Laboulbène was the stomachal mucous membrane: 1st, because no glands had been found in it; 2nd, because one could not readily understand how the patient would be able to withstand so serious a lesion.

M. Villemin thought that the presence of conjunctive and elastic fibres was sufficient to characterise the stomachal mucous membrane: the glands are very fragile organs, and had very readily disappeared on contact with the acid.

THE CANADIAN
Journal of Medical Science,

A Monthly Journal of British and Foreign Medical
 Science, Criticism, and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by sending their addresses to the corresponding editor.*

TORONTO, JUNE, 1878.

MEDICAL EDUCATION.

After eight years' experience of medical education as established by the Ontario Medical Council, the attention of the profession and of their representative body may very properly be drawn to defects in their system, as laid down and as carried out, and suggestions may appropriately be offered as to the direction and manner in which we would have it amended. The principle has readily been affirmed, that the education of our medical students should be as practical and demonstrative as possible; but to say that it ought to be so, and to make it so in point of fact, are two widely different things, which discrepancy will continue until greater facilities for practical and demonstrative examinations are provided. *Our students are too much lectured too, and too little taught,* and this will obtain just so long as the Council demands so many courses of lectures and attendance on so many lectures in each course. The want of clinical material from which to instruct students can no longer be urged as an excuse for the necessity of excessive and often wearisome didactic teaching. Our hospital, under the management of the present Board of Trustees, affords abundant opportunities for clinical study, and the policy of centralizing so many of our city medical charities will shortly greatly increase them. In addition to the wards of the Toronto General hospital, with its out-door department and department for diseases of the skin, there will be in close proximity the new Fever Hospital, the Lying-in Hospital, and the Eye and Ear Infirmary, making Toronto second to no place in Canada in facilities for demonstrative teaching and for obtaining a practical knowledge of medi-

cine. But under the present system, students to comply with the requirements of the Council, have to put in so much time attending lectures, that they have but little left during the winter session to devote to hospital work and the dissecting room, and during the summer but few remain in the city to pursue their studies. One of the first reforms we should like to see carried is that of laying down a definite course of study which students must follow each year. What greater proof of the necessity of this can there be than the fact that at present a student is allowed to take a full course of lectures and in his first session may, according to the timetable of one of our schools, attend a lecture on medicine at 8 a.m.; on surgery at 9; on obstetrics at 10; on materia medica at 11: he then may dissect, attend the hospital at 1, return to his dissections at 2, hear a lecture on anatomy at 3, one on chemistry at 4, take practical chemistry, microscopy, or sanitary science at 5, botany at 7, and at 8, finish up with physiology. The teachers see the evil and know the remedy, but they cannot increase the time for laboratory, hospital, or dissecting-room work, because some students, to whom time and money are a greater object than the acquisition of sound knowledge, may wish to attend a full course; and thus, in the competition of schools, the lectures have to be arranged to suit them, and two lectures—one on a primary and the other on a final subject—cannot go on at once. It is high time, too, that a short summer course should be adopted. It cannot be worked successfully unless made compulsory by the Council; and there is no reason why botany, microscopy, part of materia medica, practical chemistry, and toxicology, and even medical jurisprudence and sanitary science, should not some few, or all of them, be taught in a summer session, and thus lighten the amount of lecturing in the winter. With the plenary powers with which our Council has been endowed, with so many teachers among its members, it is astonishing that some of these reforms have not been more strongly advocated during the past eight years. We hope it is not the fault of the territorial representatives, for if so, we shall more strongly than ever oppose the ridiculous proposition to increase their

numbers. Educational bodies in England, though defining the time to be spent in medical study, show a disposition to diminish the number of certified didactic courses and to increase the hospital work.

The General Medical Council of Great Britain, last summer, passed a resolution with reference to the definition and limitation of the areas of examination on the most oppressive subjects. Students are no longer to overload their memories with every fact and detail within the wide-reaching limits of *chemistry* and *materia medica*, but certain regions are to be mapped out, within which their knowledge is expected to be precise and accurate.

Dr. Farquharson, in a letter to the Editor of the *British Medical Journal* of March 2nd, referring to the *materia medica* examinations, says very forcibly, "So long as the teaching is compelled to continue on its present footing, so long do we perpetuate the vices of grinding in its worst form. . . . No amount of lecturing power can galvanize any interest into pharmaceutical detail, and the student most naturally postpones all attempts at acquiring any familiarity with so distasteful a subject until the coming event of the examination begins to cast its grim shadow before; and no sooner does he become a qualified man, than he restores the elasticity of his brain by casting much of its tightly-packed cargo overboard. Far be it from me, sir, to advocate any reduction of the due amount of knowledge possessed by medical men, but there comes a point when mental training as conducted by practically useless things, must cease, and all the time at command be devoted to the mastering of the actual facts and details of future professional life."

We think we have reached that point in Canada, and look to the body that has the power to apply the remedy. Do our territorial representatives take any interest in this important matter? Do our territorial associations—where they exist—ever discuss it, or any other subject pertaining to medical legislation? If so, do they instruct their representatives to take steps in the right direction? Do they ever give him any assistance at all? We think, as a rule, they do not.

It is a matter for regret too, in our opinion, that many members of the Council are averse to having many teachers as examiners—placing their own desire for the position before the interests of the students, the profession, and the people.

Surely a glance at some of the questions given at the late examinations, which, to give point to our argument, we print elsewhere in this number, will at once convince them that our oft-expressed views are sound, and that teachers make by far the best examiners, and that they only should examine, but not in their own subjects of lecturing. We have been, in Ontario, far in advance in our efforts to obtain a high standard of medical education, and our friends across the line have awakened to its advantages. At Harvard University, where, under the new *regime*, no student can go from one year to another without passing an examination on certain subjects, we see from the report of President Eliot that the change has been pecuniarily and scientifically successful, and in three years a surplus of \$25,000 has been accumulated and the percentage of students holding literary and scientific degrees has risen to forty-one per cent. Seven years ago, it was twenty-three per cent. The adoption last year of the three years' course in Philadelphia has been followed by a similar result.

In an able editorial in the *Ohio Medical Recorder*, the subject we have discussed is fairly put, though we are glad to say that many of the remarks can not be applied to our Canadian schools. It reads;—"It is the method itself which we consider at fault. Our present method makes—theoretically at least—*scientific* doctors: they will give, with perfect precision, the symptomatology and differential diagnosis of typhoid fever; its pathology they will discuss, with frequent references to Wagner and Rindfleisch, and they will treat it and its complications most learnedly and with scrupulous regard for the 'physiological action' of remedies. All this before graduation. We will admit that our present system, if properly conducted, is capable of producing finished doctors so far as their theories are concerned. But the young doctor may be compared to a young chemist, who, well prepared in

theory, is inexperienced in the use of apparatus. Put such a man into the laboratory and, however cautious he may be, broken bottles and beakers and retorts will evidence his lack of skill in manipulation; and with the young doctor and his patients, it will be assuredly a miracle of grace if broken constitutions and funerals do not evidence *his* lack of practical skill.

"The young chemist should be instructed in manipulation under the immediate supervision of his teacher; and the young doctor should be instructed in the practical handling of drugs and patients under the direct supervision of competent teachers in hospitals.

"Increase somewhat the number of *internes* in our public hospitals; make all appointments *only* after a competitive examination; limit the term of residency to six months, or, if necessary in order to keep up the supply of doctors, to even three months; require every candidate for a degree to have served his term in hospital, and the thing is accomplished. With such requirements, most of the poorly qualified would not enter the lists at all, the balance could not pass the competitive examination, the best men only would enter the hospitals, and graduates would have had from three to six months *experience* before entering practice. We think we would be willing to trust both ourselves and our neighbours in the hands of such graduates."—Let us then not be satisfied with having done well, but make *Excelsior* our motto, and one and all join in perfecting our system by encouragement and advice, and when, as in the present case, the occasion offers, by judicious criticism and even reproof. *Appropos* of the latter, we may quote the following from the *London Lancet* of February 9th, "It is to no purpose to create costly bodies for examining medical men, and another costly body for supervising these bodies—all, by the way, supported solely, and most unjustly, by the medical profession—and then to connive at unqualified practice. The penal clauses of the Medical Act are the complement of those clauses which empower the examining bodies to enact high degrees of knowledge as a condition of qualification and registration, and they should be efficient, as they are not now."

Dr. E. W. Spragge has been elected representative of Trinity College, in the Ontario Medical Council.

HOSPITAL APPOINTMENTS.

We clip the following "Annotation" from the *London Lancet* of December last, which, we think, contains some very pertinent remarks upon this subject and might, very properly receive the favourable consideration of those having the management of hospitals here and elsewhere. The writer says:—"The occurrence of a resignation by one of the surgeons of the South Devon and East Cornwall Hospital has given occasion for the discussion of a very important question—that of the desirable duration of hospital appointments. We congratulate the public of Plymouth on having both sides of this question well stated to them in newspaper letters, and a very able judgment in the columns of the *Western Daily Mercury*. Our contemporary goes in decidedly for the limited duration of appointments without the right of reelection, arguing that the tenure of hospital appointments is one of the most valuable means by which the efficiency of practitioners can be promoted, and consequently, that this advantage should be shared as largely as possible by the medical men of a hospital town. We concur fully in this view, which is also forcibly and candidly expressed by Dr. Mures and Mr. Iago to the *Mercury*. While we think that, as a rule, appointments should cease at the end of, say, ten or fifteen years, and that the rule should not be broken without good reason, we think that the rule should not be absolute. Every now and again there rises up in a town a man of conspicuous genius and merit to whom a longer tenure of office should be accorded in the interest both of the public and the profession. But, with this qualification, we are in favour of a far more extensive distribution of the privilege of hospital appointments than at present obtains, for this among other reasons, that we are persuaded that the qualities which make a good hospital physician and surgeon are far more extensively diffused than is generally believed, and are by no means confined to the two or three men in a town who happen to be the sons of retiring officers or the personal friends of members of the Hospital Committee."

The above article places this question in so reasonable a light before the public that we

have thought we could not do better than copy it *in extenso*. We have long felt that some modification of the present method of making appointments upon the professional staff of our General Hospital would be a most desirable thing, not only in the public interest, but in that of the profession generally. We look, too, upon the present crisis in the history of our General Hospital, when our enterprising Board of Trustees are making such important changes for its increased efficiency in every particular, as a fitting occasion for some changes such as will have the effect of placing the great advantages of hospital practice at the disposal of as large a number as possible of the profession in the city. It will not be questioned for a moment, we think, that there are a number of medical men here who are anxious to improve themselves in the practical pursuit of their profession, and who would be successful, but whose opportunities in general practice are so scanty as to render the path to eminence a very difficult one.

Recently, a very handsome fever wing has been added to our General Hospital, which, from its isolation from the main building, will more effectually secure the purposes of a fever ward, and supply a long-felt want to the public. We are pleased, also, to learn that arrangements have been finally completed for the transfer of the Burnside Lying-in Hospital to the General Hospital Board, and that a wing is now in process of erection where lying-in cases alone will be admitted. This, we are bound to say, is another step in the direction of increased efficiency. The treatment of diseases of the eye and ear has now become so essentially a special branch of surgical practice, that a ward devoted to the treatment of this class of cases has become an important desideratum; and we are exceedingly gratified to note that the Board are taking the necessary steps for placing such a ward at the disposal of the public.

Now all these changes in the former position and general arrangements of the hospital justify the conclusion that a re-arrangement of the medical staff upon some more satisfactory basis than now obtains has become necessary. What should be the character of these changes? The

new Act relating to the management of the General Hospital provides for the appointment of assistant physicians and surgeons. In addition, we observe, by the last report of the Toronto Eye and Ear Infirmary, that the government has withdrawn its usual aid to that institution, and transferred it to the General Hospital by providing for the erection of an Infirmary in connection therewith. So that, with all the additions now arranged for, the operations of the General Hospital will assume a very much more extensive area; and these changes will not only justify, but necessitate much greater provision in the direction of medical attendance. We think, therefore, that the first step should be the appointment by the Trustees of a full staff of assistants. The objections which may have heretofore existed against this arrangement will have been fully overcome by the necessarily large increase that will occur in the number of patients that will be under treatment in the several departments of the hospital. By such an arrangement, the senior members of the staff would still retain their rank, while their assistants would acquire experience with them such as can only be acquired in the wards of a General Hospital.

We venture to express the hope that the worthy gentlemen who now constitute the Trust Board will not be influenced, in their selection of medical men, by any personal or political considerations, such as are indicated in the extract we have given. We submit that it is not just to men who are known to be earnest in the pursuit of their profession and whose success has proved to be fully equal to that of their neighbours, that they should be overlooked for others who have no higher claims than personal or political influence. Young men should not be disheartened in the struggle for position in the profession by the ever-recurring reflection that, because they have not influential family relationships, or because they do not desire to be judged by such influences, but upon their own personal merits, they must forever be kept in obscurity. Goodness knows, the struggle which they have for professional standing in a city like this is sufficiently severe without their being continually reminded by their failures in securing appointments that they have no

"*friends at court*," as we commonly hear it expressed. From a personal acquaintance with the present Trust, we are confident in saying that they are men possessed of powers of discrimination and honesty of purpose which will keep them above any such considerations as those indicated.

There is a great deal of force in the idea that, except in very rare cases, hospital appointments should have a limited duration. It will be apparent to anyone who is at all careful to inquire into the matter, that, without a definite limit to these appointments, a large number of medical men can never hope to reach them at any age when they could make them of any value in a practical way. If we cannot get the experience that is acquired in a hospital during the first ten or twelve years of professional life, the time has passed when it will serve anything like as valuable a purpose in giving increased efficiency to our labours. And, therefore, when we have but one General Hospital, and so many men whose claims to appointments are alike strong, it is impossible that all can be gratified under the existing mode of appointing the medical staff.

But we think that, if it were so arranged that every appointment made upon the medical staff of the hospital should terminate after a certain length of time, very much greater satisfaction, both to the profession and the public, would be the result. No one will deny that there is no profession in which the most extensive and varied experience that can be obtained is so important as in that of medicine. Scarcely a day passes without the occurrence of a case in which we feel the want of the kind of experience obtained in a General Hospital only. There, if we so desire it, we get the benefit, not only of all the cases coming under our own care, but also of every case possessing any interest that is admitted into the institution. Well, it is only reasonable to suppose that in an institution where the average number of patients is in the neighbourhood of two hundred, a vast amount of information is obtained that we would absolutely fail to secure, within any reasonable limit of time, in private practice. If, then, it be admitted that extensive experience is so important a desideratum for eminent professional success, we are

only speaking in the interest of the public when we claim that professional appointments should be available to as large a number of the profession as possible. This can only be accomplished by attaching a limit to the time for which they may be held. If appointments can continue during pleasure or for an indefinite period, it is manifest that only a very small proportion of the profession can hope to secure them at a time when they will be of any practical value. We are inclined to suggest, therefore, that no appointment should extend over a period longer than ten years.

To meet the suggestion made in the *Lancet*, we would propose that, on the retirement of any member of the regular staff whose services have been eminently valuable, so as to render his counsel desirable, he should be appointed upon the consulting staff of the hospital. We are free to admit that there are men amongst us whose labours upon the regular staff have been so eminently successful; in every way, as to render their counsel, in difficult cases, of the first importance. Hence, to adopt any measure which would result in the severing of their connection with the hospital entirely, would be a great mistake. But if they are willing that their services should be retained as consulting physicians or surgeons, every end would be fully met. We see no valid reason for limiting the number appointed upon the consulting staff; and we would, therefore, favour the continuance, in this capacity, of every man of prominence who has served a term upon the regular staff.

In making the suggestions now offered, we trust it will be distinctly understood that no selfish motives have prompted us. We are desirous that hospital advantages may be placed at the disposal of as large a number of the profession as possible. We are confident that such a modification of the present arrangement of our General Hospital as we have now indicated would be greatly in the interests of the profession, by more eminently qualifying them for the grave responsibility of their calling, and thus rendering their services, in every way, more acceptable and valuable to the general public.

LACTOPEPTINE.

As will be seen by the advertisement in another column, the New York Pharmacal Association have purchased all the rights of Messrs. Reed and Carnrick in the very valuable compound of pepsin, pancreatine, ptyalin, lactic acid, hydrochloric acid, and sugar of milk sold under the above name. Samples of this preparation have been very widely distributed amongst physicians throughout the country, and we doubt not their experience of its use has been, like our own, uniformly favourable. We can most confidently recommend it in all forms of atonic dyspepsia.

OBITUARY.—It is our painful duty to announce the sudden death of Dr. Henry, sr., of Toronto, at the age of 70. The deceased gentleman was well known in Orangeville and surrounding country, having resided at Sand Hill for nearly forty-five years, during which time, and up to the present, he was actively engaged in his professional duties. About four years ago he removed to Toronto, where he died on Saturday morning, 4th inst. Not feeling well he arose and took a large dose of morphine to quiet his nerves and procure sleep, but in a very few minutes poisonous symptoms became manifest and almost immediately he sank into a deep sleep from which he never awoke, notwithstanding the united efforts of the medical gentlemen in attendance. The deceased was a member of the Royal College of Physicians and Surgeons, Ireland, receiving his diploma in 1827; after which he spent three years in the University of Edinburgh and took the degree of M.D. in 1831. He was in the navy for a short time as Assistant Surgeon, but sold out and came to Canada in 1855, where he spent the greater part of his life in the active prosecution of his professional duties. His death, professionally and otherwise, is a loss not easily filled, for medical men of his ripe experience and undoubted skill are few in number. He was a kind father and a warm friend, and his loss will be sadly felt by many patients and friends all over the country.

The Ontario Medical Council meets at two o'clock p.m. Tuesday, 11th June, 1878, City Council Chamber, City Hall, Toronto.

JOURNALISTIC.—*The Obstetrical Gazette*, a monthly journal devoted to Obstetrics and Diseases of Women and Children, Cincinnati, Ohio, edited by Edward B. Stevens, A.M., M.D., is a new aspirant for journalistic fame. The first number is to appear the first of July, 1878.

Our thanks are due to Dr. Pyne, the Registrar, for the readiness and courtesy with which he has, in spite of his arduous duties, given us information in Council matters.

CANADIANS IN ENGLAND.—H. L. Reddy, M.D., has been admitted licentiate of the Royal College of Physicians, London: J. C. Cameron, M.D., McGill, has obtained the license in Medicine and Midwifery of the Royal College of Physicians of Ireland.

APO MORPHIA.—The amorphous, which is a greyish powder, should never be used, as it varies greatly in strength; the most reliable salt is the muriate *in crystals*—dose, one-tenth to one-fourth of a grain as an emetic.

M. Pierre Picard will succeed Claude Bernard in the Chair of Physiology at the College of France. M. Leon Voillemier, the distinguished French surgeon, died recently.

We take the following statement from the remarkable speech of M. Leon Lefort at the *Académie de Médecine* lately on the subject of the dressing of wounds: "Taking amputation of the thigh as an example, we find that (1) with the ordinary dressings Billroth had a mortality of 82 per cent., Syme, 44, Spence 31; (2) with the cotton-wool dressing, Guérin 50, Ollier 60; (3) with intermediate reunion, Azam's mortality was 30 per cent.; with Lister's dressing, Lister's mortality was 26 per cent., Bardeleben's 62, and Volkmann's 30; (4) in the absence of all dressing, Rose's mortality was 28 per cent., and Leon Lefort's own, 21 per cent., he observing the most rigorous cleanliness alone.

BOOK NOTICE.

Is Modern Education Exerting an Evil Influence upon the Eyesight of Children. By A. W. Calhoun, M.D., Atlanta, Georgia.

Miscellaneous.

Dr. Nathan Bozeman has been appointed to the staff of the Women's Hospital, New York.

Mr. Edward Nettleship has been elected Ophthalmic Surgeon to St. Thomas's Hospital, in place of Mr. Liebreich, who has resigned.

J. Rirdon Bennett, M.D., F.R.S., has been re-elected President of the Royal College of Physicians for the ensuing year.

Dr. Trenholme has resigned the Chair of Midwifery and Diseases of Women and Children in the Medical Faculty of Bishop's College. Dr. Blackader has been appointed Lecturer on Physical Diagnosis in Bishop's College.

Dr. Francis Gurney Smith, Professor of the Institutes of Medicine in the University of Pennsylvania, died last month. He was well known as the editor of the American editions of Carpenter's and Marshall's Works on Physiology.

UNIVERSITY OF TORONTO.—We are informed that the Senate of Toronto University will accept the matriculation of the examiners for the Ontario Medical Council until October 18, 1878.

UNIVERSITY OF TORONTO.—The election of members of the Senate to replace those retiring this year resulted in the choice of J. M. Gibson, M.A., LL.B., of Hamilton; J. H. Richardson, M.D., of Toronto; and James Bethune, LL.B., Q.C., of Toronto. S. Woods, M.A., of Kingston, was elected to replace W. R. Meredith, M.A., of London, who resigned his seat this year.

MISTLETOE AS AN OXYTIC AND FOR UTERINE HÆMORRHAGE.—Dr. W. H. Long, Surgeon U. S. Marine Hospital Service, Louisville, Ky., (*Louisville Medical News*, March 16, '78), states that he has used this plant as a substitute for ergot for the past ten years. The infusion, decoction or fluid extract of the leaves may be employed.

TORONTO SCHOOL OF MEDICINE SCHOLARSHIPS.—1st year, \$50, 1. James H. Duncan, 2. W. E. Hamill, 3. John Ferguson; 2nd year, \$50, 1. W. J. Cross, 2. Matthew Wallace, 3. David Gould; 3rd year, \$50, 1. James Adair, 2. Franklin Burt; 4th year, instruments, value \$50, 1. John Herbert Gardiner, 2. George Kennedy, 3. W. F. G. Grant.

UNIVERSITY OF TORONTO.—Annual Examinations in the Faculty of Medicine:—Gold medal, Griffin; silver medal, 1. Meek, 2. Bonnar, 3. Kennedy, 4. Gardiner. Starr Gold medal, Bonnar; Starr Silver, 1. Meek, 2. Griffin. *Scholarships*, 3rd year, Burt, 2nd year, Cross, 1st year, Duncan and Hamill, *æq.* Following are those who passed the final examination (for M.B.) in medicine:—J. Adair, Algie, Ashly, Bonnar, A. Baines, W. H. Bently, W. H. Burton, C. K. Clarke, Cornell, Dafoe, DeLom, F. J. Duggan, Doupe, Gardiner, S. H. Glasgow, Griffin, Groves, Hartman, D. Jamieson, J. R. Jones, Kennedy, J. E. Langstaff, McCarthy, McGrath, Meek, McKay, A. S. Ogg, J. Pomeroy, R. A. Pyne, Rankin, W. T. Robson, A. Robinson, J. Ross, Stanley, Stalker, A. Wilson, H. D. Wilson, J. F. Vanderburg.

UNIVERSITY OF TRINITY COLLEGE.—M.D.—R. J. McKinnon, D. A. Stewart, A. H. Miller, F. M. Strangeways, D. W. Mitchell, Stewart McArton. M.B.—Harry Meek, J. D. Bonnar, W. A. Dafoe, J. Hartman, W. McKay, W. Cornell, W. H. Doupe, J. W. Groves, David Wilson, J. McGrath, J. Henderson, Chas. Sheard, U. M. Stanley, James Rankin, J. Algie, J. Forbes, J. Dunfield, D. Brook, S. A. Cornell, A. Wilson, F. H. Ashby, A. McKelvey, H. A. DeLom, D. L. McCort, A. Baines, J. E. Morrison, M. Stalker, Alexander Davidson. *Honour List*.—University gold medal, Harry Meek; silver do., J. D. Bonnar; certificate of honour, W. A. Dafoe.

ON THE TREATMENT OF INFANTILE IMPETIGINOUS ECZEMA.—Dr. Georges Lepage has observed in M. Jules Simon's wards the good results obtained in children suffering from eczema by the method recommended by Besnier (*Bulletin de Thérapeutique*, vol. lxxxviii. p. 49), which

consists in enveloping the parts attacked with India-rubber cloth. The conclusions of his paper are as follows: 1. Impetiginous eczema is a cause of debility in the child; it therefore requires prompt and active treatment. 2. Treatment by swathing is superior to all other methods. 3. The general treatment is a necessary supplement to the swathing. 4. The practitioner need not dread repercussive phenomena if the therapeutic treatment be carefully conducted.—*London Med. Record.*

VACCINATION WITH HORSE LYMPH.—Several cases of vaccination are reported in which humanized horse-lymph was used. It was almost always successful, causing beautiful pustules with less inflammatory reaction than with cow-virus. The eruption and maturation of the pustules were delayed, the former one-and-a-half to two, and the latter three to five, days.

MOTE FROM THE EYE.—Take a horse-hair and double it, leaving a loop. If the mote can be seen lay the loop over it, close the eye, and the mote will come out as the hair is withdrawn. If it cannot be seen, raise the lid of the eye as far as possible, and place the loop in it as far as you can, close the eye and roll the ball a few times, then draw out the hair. The substance which caused so much pain will be sure to come with it.

At a meeting of the *Société des Sciences Médicales de Lyon*, M. Bard, interne des hôpitaux, read a note of obliteration of the brachial in a fracture of the lower extremity of the humerus, without external wound. The internal tunic of the artery alone was injured. Gangrene of the limb and death followed. M. Poncet supplemented M. Bard's case by another, observed by himself four years ago in Saint-Sacerdos ward. A heavily-laden waggon passed over the thigh, compound fracture of the femur resulted, some days after, gangrene of the limb, and the death of the patient occurred. At the autopsy, the femoral artery presented a rupture of the internal tunic. The other coats were uninjured. The only difference to be observed between these two cases is, that in M. Bard's patient no wound existed.

ACETONÆMIA IN DIABETIC COMA.—The following are the results arrived at by Dr. Balthazar Foster of Birmingham, in relation to this subject.

1. That acetone has been found in the breath, urine, blood, etc., of patients who have died from diabetic coma.

2. That grape sugar may be converted in the stomach by alcoholic and acetic fermentations into acetone.

3. That the changes in the blood observed after death from diabetic coma can be artificially produced by the addition of acetone.

4. That the administration of acetone in large quantities to animals produces similar symptoms to those observed in diabetic coma.

TREATMENT OF SPERMATORRHŒA.—Dr. Ultzman of Vienna, recommends ext. secalis cornut. m.ij, and gr. xlv. of potass. bromid., daily, for cases of seminal emissions, but he places most reliance on local applications. He advocates the daily passage of a metal sound (7 or 8), and he leaves it in the urethra twenty to thirty minutes. Dr. U. finds that the patient is cured by this treatment in from 6 to 8 weeks. In very sensitive persons he uses urethral suppositories, (made of morphia gr. 1-3, tannin gr. vii., butyr de cacao, gr. xxx). He introduces the suppository into the prostatic portion of the urethra by means of Dittel's catheter, every other day. Later on he uses suppositories of argent. nit. gr. 1-5, butyr de cacao gr. xxx. In true spermatorrhœa he has found electricity of much service. He applies one pole within the rectum, and the other to the perineum just behind the scrotum.

Dr. Rezek of Teplitz, says the best treatment for spermatorrhœa and seminal emissions is regular sexual intercourse.—*Schmidt's Jahrbücher*, No. 3, 1877.—*Canada Med. and Surg. Journal.*

BRAIN IN RELATION TO SEX.—At a late meeting of the *Société Médicale des Hôpitaux*, M. Luys asserted that the brain of man and that of woman presented certain differences which enabled them to be distinguished from one another. In man, the paracentral lobe makes a projection from the curved line of the

brain surface, whilst in woman (except in special instances to be referred to subsequently), the paracentral lobe makes no projection, but preserves the equal and gentle curve which the brain surface presents in this region. M. Lays presented drawings of, and, the brains of men and women, hardened by his process, in which it was easy to observe these differences. . . . Lastly, M. Lays showed several drawings representing sections of the brains of insane women who during their life had been in a continual state of agitation; in these brains, it was easy to recognise a turgescence, and sometimes even a veritable gibbosity of the paracentral lobes.—(*Gaz. des Hôp.*)

THERE WERE GIANTS IN THOSE DAYS.—The Committee of the French Academy recalled an account of a quite extraordinary fecundity that was published by M. Hermann in his "Travaux Statistiques de la Russie." Fedor Vassilet, peasant of the Government of Moscow, and who, in 1872, was aged 75 years, had had, by two wives, 87 children. His first wife in 27 accouchments, had sixteen times given birth to twins, seven times to triplets, and four times to quadruplets; never a single child. The second was similarly fruitful, and bore 18 children in eight accouchments. In 1872, 83 of the 87 survived. This fact is stated to be nevertheless authentic. M. Khanikoff, correspondent of the Imperial Academy of St. Petersburg, was consulted a few years ago, as to the means to pursue in order to obtain a verification of the phenomenon. He replied that all investigation was superfluous; that the family in question still existed in Moscow and that it had been the object of favours from the Government.

REGISTRATION OF DISEASE.—The Boston City Board of Health has lately issued a circular which will be interesting to our readers in relation to a matter much discussed now, and which will probably be the subject of legislation. We give the following extract:

"Whereas diphtheria is a disease contagious and dangerous to the public health, and whereas it now exists in the city of Boston; therefore the Board of Health issues the following notice: That on and after January 1st, 1878, the follow-

ing provisions of Chapter 26 of the General Statutes will be strictly enforced.

"Sect. 47. When a householder knows that a person within his family is taken sick of.. any...disease dangerous to the public health, he shall immediately give notice thereof to the ...board of health of the town in which he dwells. If he refuse or neglect to give such notice, he shall forfeit a sum not exceeding one hundred dollars.

"Sect. 48. When a physician knows that any person whom he is called to visit is infected with...any disease dangerous to the public health he shall immediately give notice thereof to the ...board of health of the town: and if he refuses or neglects to give such notice, he shall forfeit for each offence a sum not less than fifty nor more than one hundred dollars."

NOTE ON THE HARDENING AND PRESERVATION OF PATHOLOGICAL SPECIMENS.—After many experiments with different fluids, I have as yet found no better fluid for the purpose of hardening and preserving museum specimens than a strong alcoholic solution of carbolic acid and creasote. The carbolic acid should be dissolved in a little spirit, and the creasote then added: a clear solution results, which is not altered by the subsequent addition of the methylated spirit; and the following proportions are recommended for the purpose: Creasote, 1 part; carbolic acid, 1 part; methylated spirit, 38 parts. The hardening of lung-tissue, with which I am chiefly concerned, is not easily effected by alcohol alone, and mucous tissue and fluid loses a large quantity of water before hardening; but, with the above fluid, the larynx is very rapidly hardened, and tubercle, which completely alters its macroscopical appearance in alcohol, is better shown after immersion in this fluid than in any other that I have yet tried; the colouring matter of the blood is but little altered by it, and may be thus preserved for some time. For putting up specimens, glasses, with a glass cover ground at the edges to fit close, are well suited. These are often glued together with shoemaker's glue; but as there is much risk from the heating of this substance, and as the glue is soluble in spirit, I have altogether discarded this method and use diamond cement. This is solution of gelatin in acetic acid, which is readily softened by the application of hot water, is easily applied by a brush, and is insoluble in spirit.—REGINALD E. THOMPSON, M.D.

LYMPH SCROTUM AND THE FILARIA SANGUINIS HOMINIS.—At a late meeting of the Pathological Society of London Mr. G. C. Coles exhibited a specimen of lymph scrotum which consists in a varicose condition of the scrotal lymphatics, followed by inflammation of the skin and exudation of a clear and subsequently milky fluid. He pointed out the relation between this affection and elephantiasis on the one hand, and chyluria on the other. Lewis discovered the existence of filariæ in cases of chyluria, and the parasites were subsequently shown to exist in cases of lymph scrotum also. Dr. Bancroft, in Australia, last year discovered the mature worm (called by Cobbold *Filaria Bancrofti*), of which the *Filaria Sanguinis Hominis* is the larval form; and it appears from Dr. Manson's (of Amoy) researches that the mosquito serves as an intermediary host between these two. He found that, taken into the stomach of the mosquito (he had counted as many as 120 in one mosquito) the filaria casts its skin and assumes a sausage shape, the female depositing her eggs on the surface of the water and dying there. The filariæ are introduced into the human organism by the drinking water, and produce varicosity of the lymphatics by mechanical obstruction.

Dr. Hughlings Jackson has been the recipient of the first award of the Marshall Hall Memorial Prize of the Royal Medical and Chirurgical Society for his investigations into the Pathology of the Nervous System. The Fothergillian Gold Medal of the Medical Society of London has been awarded to Dr. J. Milner Fothergill for his essay on the Physiological Antagonism of Certain Poisons. The silver medal of the same society has been awarded to Dr. J. Althaus for the best paper of the session; the subject of the paper being the Lesions of the Anterior Cornua of the Grey Matter of the Spinal Cord. This paper appears in the April number of the American Journal of the Medical Sciences. Dr. Cohnheim, Professor of Pathological Anatomy in Breslau, has accepted an invitation to the same chair in the University of Leipsic, and is succeeded by Dr. Ponfick, Professor in Gottingen. The Sixth International Medical Congress will be held in Am-

sterdam in September, 1879. We are informed that Mr. Jonathan Hutchinson is likely to succeed Mr. Erasmus Wilson in the Professorship of Dermatology at the Royal College of Surgeons, England. Mr. Richard Liebreich has resigned the post of Ophthalmic Surgeon to St. Thomas's Hospital.

TIERAPEUTICS OF IRON.—There are two different states found in women where iron is either totally contra-indicated or to be given with great caution. The first is a condition of amenorrhœa in florid, plethoric persons. The other is the opposite condition of menorrhagia in certain females. There are cases of menorrhagia associated with pallor and debility, where the usual compound of iron and extract of ergot is not so useful as a non-chalybeate treatment. In these cases it is not any imperfection in the process of blood manufacture which is to be remedied, for the blood is made rapidly and quickly, only to be lost at each menstrual period. It is here desirable rather to limit the rapidity of the blood formation, so that when the vascular turgescence of the menstrual period comes, it will not find the blood vessels too distended with blood. This will lead to diminished catamenial loss, and so the blood waste will be economised. According to the experience of Dr. Brown Séquard and Dr. Hughlings Jackson, iron does not suit epileptics. It increases the tendency to fits. It may improve the general condition, but it aggravates the epilepsy.—*Dublin Medical Press.*

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.—List of the names of persons who obtained the License of the college at the Spring Examinations in 1878:—James Adair, James Algie, Thos. H. Ashby, Allan W. Baines, Henry Bennett, William H. Bentley, J. D. Bonner, Franklin Burt, John D. Cameron, Arthur D. Campbell, Charles Kirk Clarke, George Clinton, Sandford A. Cornell, Warren Cornell, Hugh A. Craig, William A. Dafoe, Henry Anthony De Lom, William A. Doupe, Joseph Fredk. Duggan, John Dunfield, Henry Alfred Evans, D. W. Faulkner, John Munro Forbes, John B. Fraser, Sinclair Holden Glasgow, Wm. Frank G. Grant, John F. Gilmour,

John H. Gardiner, James Wilson Groves, Edw. Anson Graveley, Fred. S. Greenwood, K. D. Graham, Jacob Hartman, Francis Melville Howe, James Bruce Howell, Theod. St. Val. Hutchinson, James Robert Jones, David Jameson, George Allan Kennedy, William B. Kennedy, P. E. Kidd, George W. Kirke, Onesine Langlois, John Elliott Langstaff, William Lehman, James Henry Lowe, Denis P. Lynch, Fred. William Lewis, James Macarthur, Harry Meek, James Morrison, Thomas Millman, Thos. W. Mills, Dan. C. McCarthy, Milton McCrimmon, Thos. John McCort, Geo. R. McDonagh, John McGrath, William McKay, Alexander McKelvey, James McLellan, J. W. Neilson, Alexander Ogg, John R. Pomeroy, Robert Allen Pyne, J. P. Rankin, George Riddall, James W. Ross, William Telfer Robson, Alexander Robinson, Robert Reddick, Charles Shupe, Charles Sheard, Malcolm Stalker, Uriah M. Stanley, Daniel Fisher Smith, James Vanderbug, Archibald Wilson, David Henry Wilson.

NOVEL METHOD OF ADVERTISING SPECIALTIES.—“The Eye” and “The Ear” were toasts at the banquet of the Kentucky State Medical Society a few weeks since, and specialists were on hand to respond. In referring to this vulgar proceeding, the *Richmond and Louisville Journal* advises that the advertising field should be enlarged, and suggests as some of the additional toasts “The Chancre,” “The Urinary Bladder,” and “The Rectum.”

TREATMENT OF URETHRAL NEUROPATHY.—Dr. Bron, (*Jour. des Sci. Méd.*, 1878, p. 95) thus designates those vague symptoms complained of by patients who have suffered from gonorrhœa after all discharge has ceased. These are lassitude in the loins, weight in the hypogastric region, painful and strange sensations in the urethra, extension of the malaise to the digestive organs, etc. Of course all these symptoms are not found associated in a single individual, but they are found isolated or several together. Instead of the varied medication heretofore recommended in these cases, Dr. Bron urges the simple employment of the sound as being quite sufficient. A soft bougie of small size is introduced every second day and left in place for a few moments. At each sitting the size of the instrument is slightly increased. At the end of a very short series of sittings the

most rebellious neuropathies sometimes disappear, as if by magic, after having resisted the most varied medication previously.

RELATION OF ERYTHEMA NODOSUM TO TUBERCULOSIS.—Oehme (according to *Centralblatt für Chirurgie*, No. 43, 1877, 680) has observed that, though in strong and healthy individuals erythema nodosum leaves no unfavourable sequelæ, for joint affections and diseases of the endocardium do not occur as a rule, yet in persons of bad constitution or of unfavourable hereditary tendencies the advent of erythema of this character is ominous. In such cases general tuberculosis is liable to occur very soon, according to his observations; and he mentions one case where a child apparently recovered from erythema nodosum died a few weeks later of tubercular meningitis. He therefore believes the affection to be a general disease, of which the eruption is merely an early symptom.

Births, Marriages, and Deaths.

BIRTHS.

At Forest, on Sunday, the 22nd of April, the wife of Dr. Alex. Scott, M.B., of a son.

At Simcoe, on Sunday, the 12th May, the wife of James Hayes, M.D., of a son.

At Phoenix Park, Balaclava, Jamaica, on Sunday, 31st of March, the wife of Dr. J. J. Hillary, P.M.O., of a son.

MARRIAGES.

On Tuesday, the 23rd April, at the residence of the bride's father, Brant Avenue, Brantford, by the Rev. W. Wellington Carson, Levi Secord, M.D., of Bright, Ont., to Emily C., second daughter of Wesley Howell, Esq.

DEATHS.

At 37 Walton Street, Toronto, on the 4th of May, Thomas Henry, sr., M.D., aged 70 years.

On the 8th of May, at the residence of her son-in-law, Wm. J. Cameron, of H.M. Customs, corner of Haydon and St. George Streets, Ann, beloved wife of Mr. John Rutherford, and mother of Dr. Rutherford, Aurora, and Dr. Rutherford, of Chatham, Ont., aged 76 years and three months.

At Paris, on the 31st of March, Dr. Séverin Galezowski, aged 78, formerly a professor in the Polish University of Wilna.

Felix Robaud, aged 57, one of the original founders of *La France Médicale*.

Professor Ernst H. Weber, the distinguished physiologist, died in Leipzig, January 26th, aged 73.

Dr. A. H. Cenas, Emeritus Professor of Obstetrics in University of Louisiana, died January 10th.