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ON THE LOCAL ADMINISTRATION OF BICHLORIDE OF MERCURY IN CERTAIN DISEASES OF THE FEMALE PELVIC ORGANS.

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Lecturer on Diseases of Women, in Bishop's College, Montreal.

Bichloride of mercury has been used for several centuries as an alterative and absorbfacient, more especially to promote the absorption of syphilitic exudations. The mode of administration was generally by the stomach, until a few years ago, when the hypodermic method was introduced. The results from this latter method prove that the areolar tissue under the skin readily admits the drug into the general system, and were it not for the inconvenience of making so many punctures, it would present many advantages over administration by the stomach. The rectum has still later come into prominence as an absorbing surface, and as such there is no doubt that it is even superior to the stomach. The vagina has also been known to be capable of absorbing certain substances, but its exact capabilities in this direction do not seem to have been accurately observed: In a dozen standard works on physiology and therapeutics, the fact that certain substances may be absorbed by the mucous membrane of the vagina is merely mentioned in only one or two of them. That medicaments may be introduced not only into the absorbents of the pelvis, but also through them into the general circulation, has been made evident to me in a great many cases in which I have employed atropine, morphine, iodine, and iodoform, with the results that patients either showed the constitutional effects of these drugs or could taste them in the mouth. In fact, I have found it quite common for patients, who were not aware that I had painted the vagina with Churchill's solution of iodine, to tell me at their next visit that they perceived a metallic taste in their mouths shortly afterwards. The same has occasionally been true of iodoform; while in every case of hopeless cancer of the uterus in which I have rendered the path towards the grave as pleasant as possible by the local application of morphine and atropine, they have produced all the general manifestations of each of these drugs.

There is one point, however, which may be raised in objection, and of which I do not feel certain as to the answer. Granted that the abraded mucous membrane of the vagina or cervix do absorb freely, is it also true that the same takes place when the membrane presents no solution of continuity? I am inclined to think that it does, although I have not had sufficient cases presenting the required condition of being free from abrasion in order to demonstrate this point. As far as bichloride of mercury is concerned, I am positive that it is no exception to the rule, in the case of an abraded mucous surface.

I have had a case in my own practice, and I have the record of many cases in the practice of others, in which severe toxic effects have followed the simple irrigation of the vagina with a more or less strong sublimate solution. In the case in which it has occurred in my own practice, sudden diarrhœa, collapse, and suppression of the urine, but ultimate recovery, followed the post-partum introduction of a pint of a one in a thousand solution—but, of course, in this case there were doubtless many abrasions of the mucous membrane. It is also true that in the majority of cases of pelvic infiltration, with or without exudation, the epidermis of the vagina and cervix is, to at least some extent, wanting.

I have now been employing the local administration of bichloride of mercury in doses of one-tenth of a grain every three or four days, on a boro-glyceride tampon, during the last two years, about five hundred times in about fifty cases of vaginitis, endometritis, salpingitis, ovaritis, and pelvic peritonitis, and I feel sure the duration of treatment, before relief has been obtained, has been very much less than was the case before I adopted this method. Exactly how much of my success is due to the bichloride alone, I am unable to say, for the simple reason that, at one time or another of the treatment, in every case, I employed other remedies and measures in addition to it. One of my reasons for attaching so much value to the bichloride of mercury employed in this way, is that nearly every one of the diseases above mentioned is due more or less directly to septic absorption, and that the more or less constant production of septic matter is necessary to keep up the disease.

The method in which I prepare these tampons is as follows: I make seventy of them at a time of different sizes, from the best absorbent cotton, which I then plunge into a pint of distilled water colored with aniline dye, and in which a seven grain bichloride tablet has been dissolved. If a pint is too much or too little, less or more water may be added, but I find that a pint can be taken up quite easily by seventy of these tampons. Each tampon will, therefore, contain one-tenth of a grain of bichloride. Care must be taken that too strong a dose is not employed, otherwise the discharge becomes irritating to the mucous membrane of the vulva. I employ these tampons in every case in which tampons are required, sometimes using as many as three or four of them, either dry or after soaking them as well, in either glycerine or ten per cent. boro-glyceride. Although I believe that this quantity is quite sufficient to have a very material effect upon the germs of putrefaction, as well as on gonococci, the dose is quite harmless, there not being at any time in the vagina more than an ounce of a one in ten thousand solution, or one-half an ounce of a one in five thousand. I have noticed in every case in which I have employed them that the unpleasant odor of the discharges of which the patient had previously complained, has been completely removed, which alone would be enough to make it well worth while employing them. Another advantage is that tampons so prepared may be left from four days to a week without decomposing, which is greatly to be desired in cases which cannot be seen by the attendant every two days. I rarely, if ever, use pessaries, as I find, especially in cases where there are adhesions, that these tampons are painless, never light up inflammation, and are very effective in keeping the uterus and ovaries in healthy position until the cause of the displacement has been removed by other means.

I have brought this matter before you rather with the object of calling your attention to it so that as many of you as think it desirable may try it in your practice, and either condemn or approve, as you are warranted by the results.

Selections.

CEREBRAL LOCALIZATION.

(An Abstract—continued.)

The visual centres—The movements which can be excited on stimulation of the occipito-angular region have already been mentioned. Ferrier's hypothesis is that the movements of the head and eyes are the signs of the arousal of the subjected visual sensations, and due to the associated action of the frontal and subcortical oculo-motor centres. This has received confirmation from the experiments of Schafer on the latency periods of the ocular movements following excitation of the frontal and the occipito-temporal regions respectively. This would agree with the hypothesis that in the one case

the movements were reflex and in the other direct.

The fact that the ocular movements are still attainable on stimulation of the occipito-angular region, after complete removal of the frontal region, shows that they are not necessarily indicative of the association of those cortical centres, but may be due, if they are not always so, to the excitation of the oculo-motor centres of the corpora quadrigemina.

The occipito-angular region is the visual area of the cortex—complete destruction of this area in the one hemisphere causes permanent hemiopia to the opposite side by paralysis of the corresponding parts of both retinæ; while bilateral destruction causes complete and enduring blindness of both eyes. The sensibility of the eyeball is intact, and the ocular movements are absolutely unimpaired. There is no impairment of the sensibility or the motor power of the limbs. The other special senses are unaffected. If the destruction of the occipito-angular region is incomplete unilaterally or bilaterally, the resulting hemiopia in the one case is not enduring, nor is the blindness permanent in the other. Destruction of the angular gyrus, in combination with the occipital lobe, is the only lesion which causes a permanent result.

In a monkey in which Ferrier had completely destroyed both angular gyri, it was noted that for four days the animal was absolutely blind; then there were evidences of returning vision, and it was observed vision was better in every part of the periphery than in the centre. Objects held directly before the eyes and at a little distance were apparently not clearly seen and never laid hold of with precision; and the animal when examining any object always held it at full arm's length from its eyes. The phenomena observable in this animal were such as would be best explained by impairment or loss of central vision; for it is well known that when central vision is lost or impaired in man, objects are better seen at a distance than close at hand, and less distinctly when the eyes are immediately converged on them. It appears, therefore, that the symptoms resulting from bilateral destruction of the angular gyrus are best explained on the supposition that the angular gyri are more particularly related to the area of distinct vision, and accordingly with the macula lutea. The facts of disease in man render it necessary to assume that the region of the yellow spot is represented in each hemisphere, though more in that on the opposite side than on the same side, and the probability is that the area for clear vision is represented mainly in the angular gyrus of the opposite hemisphere. The results of Ferrier's experiments seem to show that the angular gyrus has relations with both eyes; the crossed action, however, is the only one which is clearly demonstrated in the lower animals.

A distinguishing test between tract and central hemiopia consists in determining whether a pencil of light thrown on the blind side of the retinæ induces contraction of the pupil or not. As the optic tract is the path of the fibres which excite pupilliary contraction through the oculo-motor centres, as well as those which excite visual sensation of the cortex, lesion of the optic tract will cause not only hemiopia, but also paralysis of the reflex reaction of the pupils to light; whereas lesion of the cortical centres will cause hemiopia, but leave intact the pupillary reaction.

There can be no question that in man and monkeys there is decussation of the optic tracts in the chiasma.

The angular gyri are more particularly the centres for clear vision, each mainly for the eye of the opposite side. Whether the other portions of the retinæ, upper, lower, outer, and inner, are specially represented in corresponding regions of the occipital lobe cannot be said as yet to have been established. It is doubtful whether there are on record any cases of strictly cortical lesions of the occipital lobe proper, accompanied by hemiopia, apart from direct or indirect implication of the optic radiations.

Irritative lesions of the angular gyrus occasionally give rise to optic illusions or flashes of light, followed by temporary amblyopia, while destructive lesions of the angular gyrus, more particularly in the left hemisphere, are generally associated with the special form of sensory aphasia termed word-blindness. Word-blindness is not necessarily accompanied by any noteworthy affection of visual sensation, though in some cases where the lesion of the occipito-angular region is more extensive, there may be

a greater or less degree of right hemiopia. On the other hand, right hemiopia, pure and simple, is not necessarily asociated with defects in visual ideation.

The fact that visual ideation, more particularly in reference to the association of written symbols with their meanings, is apt to suffer more readily than simple perception, appears to illustrate the laws of evolution and dissolution of the nerve centres which have been expounded by Hughlings Jackson; as evolution is from the most simple and most stable up to the most complex and least stable, so destructive processes annihilate first the higher and last of all the lower functional manifestations.

The visual centres in the lower vertebrates have been investigated. Hitzig first noticed the occurrence of blindness in the opposite eye from destruction of the occipital region in dogs. Though in dogs the visual area is mainly in relation with the opposite eye it is also in relation with the outer quadrant of the same eye; hence destruction of the visual centre in one hemisphere paralyses the inner three-fourths of the opposite retina and the outer fourth of the retina on the same side. But the facts recorded indicate that, for a short time at least, after the destruction of the middle portion of the second cerebral convolution, there is blindness in the opposite eye. It is likely that we have the same relations here as exist in monkeys, and that, for a time at least, after complete extirpation of the visual sphere, there is total blindness in the opposite eye. This is confirmed by the experiments of Bechterew, recently published. Bechterew finds that in dogs and cats there are two regions in the cortex related to vision; the one in the occipito-parietal region, in relation with the corresponding halves of both retinæ; the other, more especially in the parietal region, in relation with the opposite eye alone. Recent researches indicate that there is only partial decussation in the chiasma of the cat, dog and also in the rabbit.

The exact limits of the visual sphere in dogs are still the subject of some difference of opinion, but all experiments agree in including in this area the posterior half of the second external convolution. This is the convolution which in its electrical reactions corresponds with the angular gyrus and occipital lobe in monkeys.

In rabbits the visual area would, according to the homology of the electrical reactions, occupy the occipito-parietal region of the hemisphere. It has been supposed that in this animal there is complete decussation of the optic tracts in the chiasma, but later experiments lead one to conclude that a small fascicle of uncrossed, or direct, fibres exist also in the optic tract of this animal. In the mouse and guinea-pig, however, the decussation is a complete one. In pigeons, and in birds in general, the region which in its electrical reactions is homologous with the visual centre of the higher animals occupies the parieto-posterior aspect of the hemisphere, where it forms a thick lamina over the corpus striatum. It is usually stated that in pigeons a complete decussation of the optic tracts occurs in the chiasma, but some doubts have been expressed on this point.

It seemed to Ferrier that if any bird can possess binocular vision, it should be the owl, whose eyes are placed almost in the same plane. From experiments he concluded that no doubt can be entertained as to the binocular relations of each cerebral hemisphere in the owl.

Though the monkey rendered blind by total extirpation of its visual centres acquires the power of avoiding obstacles when left amidst its usual surroundings, yet this appears to be due rather to a sharpening of its other faculties, or more attentive appreciation of the impressions made on these by the objects with which it is surrounded, than to visual sensation. The question is, however, one which will bear further investigation; for if retinal impressions are coordinated with apparently purposive actions in the subordinate centres of the lower vertebrates such as fishes, reptiles and birds, there is at least the possibility that similar reactions may be discoverable in the higher animals, even though in a much less degree. It is certain, however, that the visual area of the cortex is not a mere functionally differentiated region capable of replacing, or of being replaced by, other cortical regions, inasmuch, as destruction of the visual centres leads to atrophy in primary optic centres, optic tracts, and optic nerves; and conversely, destruction of the optic radiations leads to atrophy strictly confined to the regions included within the visual zone. The differentiation of an area exclusively—so far at least

as can be judged from clinical and experimental results—would strongly favor the hypothesis that other sensory faculties are also separately localized in definite cortical regions.

ON THE TREATMENT OF RUPTURE OF THE UTERUS.

BY D. BERRY HART, M.D., F.R.C P. ED., F.R.S. ED., PRESIDENT OF THE EDINBURGH OBSTETRICAL SOCIETY, ETC.

(Read before the Obstetrical Society of Edinburgh, 14th May, '90.)

My personal experience of this disaster is based on five cases, all of whom have died. In the second case I met with I drained, but without success. In the third and fourth the patients became moribund shortly after the occurrence of the rupture; while in the fifth I did abdominal section and Prevôt's operation. Though this last case was also fatal, it presents points of interest; and as the experience of other operators has been better than my own, I have deemed it advisable to bring the subject before you to-night, so as to draw attention to the treatment of an accident too often regarded in this country as almost unavoidably fatal.

My fifth case is as follows:—

Report by Drs. Fitzgerald and Mellville. Mrs. C., æt. 41 years, residing at 3 Burns Land, Greenside Row, x.-para. Her previous children were born living and healthy. The labors were all slow and lingering, except the ninth, in which the membranes broke unexpectedly at a meal, the child being born in an hour and a half. She menstruated last in the beginning of July, and had not been very strong during the last few months. She had influenza at the New Year, and shivered for two days; she had also a cough and a pain in her left side, which appears to have been due to pleurisy.

Present Pregnancy. — Membranes ruptured when she was sitting at her dinner at two o'clock. There were no previous pains. The student arrived at quarter to three o'clock, and found the patient in bed. Her face was pale and emaciated. On palpation of abdomen, walls were tense and resistant. The uterus was felt firm and hard, but no contractions were made out. The position of the head could not be ascertained. On auscultation, the fœtal heart sounds could not be heard. On vaginal examination the vagina was roomy and moist. The os uteri was not dilated, and barely admitted the tip of the finger; no presenting part could be felt. She had had no pains up till now, except now and then very slight lingering pains at the front or the lower part of the abdomen. No pains whatever at the back. The student left at 3.20 p.m., with instruction to be sent for if the pains came on stronger. He returned at 6 p. m., and found the os had dilated considerably, and would now admit of three fingers. A smooth fleshy mass could be felt presenting, but could not be accurately diagnosed. Fœtal heart sounds could not be made out. The pains were still of the same lingering character, and all at front of abdomen. They were a little stronger than previously, but still slight in nature. She was ordered a hot douche at 6.30 p.m., and another at 7.15 p.m. At 7.40 p.m., the presentation was diagnosed to be a shoulder, and assistance was sent for to the Maternity Hospital.

The house-surgeon arrived at 8.30 p.m. The uterus was found in a state of tonic contraction. No fœtal heart sounds could be made out. Chloroform was administered, and on vaginal examination the presentation was found to be the right shoulder. The child lay in the dorso-anterior, left cephalo-iliac position. The question of turning was now discussed, and it was decided not to do so on account of the tonic contraction of the uterus and the firm impaction of the shoulder, and Dr. Hart was sent for. During the interval before the arrival of Dr. Berry Hart, patient lay quietly. There was no visible sign of any strong pain, and she exhibited no signs of collapse or shock.

On Dr. Berry Hart's arrival at 10 p.m. the administration of chloroform was at once resumed, and immediately on his palpating the uterus he diagnosed rupture. The fœtus could be palpated out high up in the abdomen, and the empty uterus felt in the hypogastric region. He passed his hand through the rent, and seizing the leg of the child attempted to draw it back through the rupture, but was compelled to desist, owing to the bowel coming with it.

Dr. Hart then proceeded to perform abdominal section; and cutting through the abdominal walls in the middle line, opened the

peritoneal cavity and lifted out the child; he also removed the placenta which had been extruded from the uterus, a small portion only remaining attached to it. The uterus was then lifted forwards out of the abdominal cavity, and an attempt made to ligature it by a piece of elastic tubing. This tubing broke, and nothing else being available, a strong piece of twine was passed round the lower uterine segment and fastened securely. (The twine was afterwards replaced by a piece of the tubing generally used for ligature of uterus in Porro's operation.) The uterus was now amputated above the lower uterine segment. Some bleeding vessels were ligatured, and the abdominal cavity thoroughly douched out with hot water. There being only one sponge available, strips of clean cloth were used in addition. The ligature clamped the stump of the uterus a little above the lower limit of the rupture in the uterine wall; but a piece of the peritoneum forming the fold of Douglas was pulled in under the loop of the ligature, and so cut off the peritoneal cavity from the vagina. The incision in the abdominal wall was closed by silk sutures, which were passed deeply, so as to include skin, muscle, and peritoneum; five or six sutures were used. The stump of the uterus was brought through the external incision, and secured in that position by transfixing it with knitting needles. The wound was dressed with iodoform gauze, and a binder applied over all. The antiseptic used was corrosive sublimate. During the whole course of the operation the patient had been receiving frequent subcutaneous injections of ether; brandy was also given.

The operation was concluded at a quarter past eleven; and the pulse being barely palpable and the patient collapsed, one of the house-surgeons left for the transfusion apparatus. In the meantime brandy was given by the mouth, and also digitalis in the form of the tincture. On the arrival of the transfusion apparatus, 27 oz. of sterilized salt solution, of strength of ʒj. to the pint of boiled water was injected into the infra-clavicular subcutaneous tissue by means of syphon action. (Temperature of transfused fluid, 100° F.) This caused no appreciable improvement in the pulse, and the patient sank rapidly, the pulse being palpable at the radial artery ten minutes before death, which occurred at twenty minutes to 1 a.m.

The child was a male and still-born; the skin was peeling off in some places. The skin over right shoulder was much discolored by a well-marked caput succedaneum on it. Placenta was normal.

This gives the account of the case from the spectator's point of views. How the case struck me is briefly as follows:—When I was summoned to the patient I took with me Braun's blunt hook for decapitation, not anticipating anything more serious. When narcosis was completed, however, and inspection was made of the bared abdominal surface, it was evident that the flattening of the recti as the patient strained pointed to something abnormal. On palpation, therefore, I was not surprised to be able to make out the fœtus distinctly through the abdominal wall, and feel the body of the uterus apart from it and below the umbilicus. I accordingly diagnosed uterine rupture, and passed my hand into the vagina to ascertain its extent. I found it to be a huge one at the upper limit of the lower uterine segment posteriorly, easily admitting the entire hand. Blood poured through the rent, and as I believed the case to be, if not hopeless, a very bad one, I thought it best to attempt delivery of the child and placenta through the rent, and then to see what next could be done in the way of treating the rupture by the iodoform gauze tampon, as has been recently practised so successfully by Leopold and others. I accordingly seized the foot of the child and drew it down, but speedily desisted, as I found that with it the small intestines were descending thorough the rent. No course was therefore left to me but the performance of abdominal section, and I did this all the more readily as I saw I could deal with the rent then either by supravaginal amputation of the uterus or otherwise, as I thought fit. One difficulty was the armamentarium, as when mustered it only amounted to one knife, india-rubber tubing, needles and thread, one pair of Péan forceps, and one sponge, which an obliging but tipsy female neighbor sacrificed for the emergency. The house was a hovel, and the light scanty, but everything depended on speed, and sending to hospital would have involved nearly an hour's delay. When the abdomen was opened venous blood poured out, so that I at once seized the uterus and passed tubing

round it. Part of the rent was still below the level of the tubing, but I was able to pull loose peritoneum from the pouch of Douglas below the constricting tube, and thus shut off the vaginal from the peritoneal cavity. I then cut off the uterus above the ligature (supravaginal operation—Prevôt's operation), made a careful peritoneal toilette, and closed the wound as already described. During the peritoneal toilette large clots were removed from the flanks. From what has been said, it will be seen that abdominal section was imperative here to extract the child and placenta. The method of treating the rent adopted seemed to me to be the best for this special case; but I wish to point out that various methods may be employed, and it requires a statistical record of all cases to help us to settle which gives the mother the best chance. I therefore now wish to make a few remarks on the treatment of uterine rupture in general. In cases of rupture where the presenting part is still in the genital tract, it is evident we must deliver it in such a way as to avoid upward tension on the uterus, and therefore craniotomy or decapitation as necessary should be quickly employed. If the rent is not extensive, local irrigation with a dilute corrosive lotion, drainage, and abdominal pressure, or tamponnade of the uterus, vagina, and rent, with iodoform gauze should be performed; when the rent is more extensive, the edges should be approximated with tenacula while the tampon is being applied.

With an extensive tear and escape of child and placenta, or any one of them, into the cavity, laparotomy is imperative for extraction and peritoneal toilette. Extensive tear means bleeding into the peritoneum, and great risk of ultimate septicæmia if the blood be not removed. The treatment of the extensive rent is the next question. Suturing alone is ineffective, takes long, and has not been followed by good results. It is in such that our choice lies between Prevôt's amputation or careful tamponing vaginally and peritoneally with iodoform gauze. Recently Coe has had a successful case where he amputated the uterus and sutured the right utero-sacral fold. In sixteen cases of this amputation five recovered. Leopold, however, has recently recorded a case where the rent involved three-fourths of the lower uterine segment, and where the uterus was only attached by the left broad ligament. In this case laparotomy was performed, the pouch of Douglas plugged with a long strip of iodoform gauze, which was applied to the edges of the tear, brought round between the right side of the uterus and pelvic wall, into the vesico-uterine pouch, and its ends out at the abdominal wound. The uterine cavity and vagina were plugged with another strip. These were left in for fifteen days, and the patient made an uninterrupted recovery. In seven cases treated thus, Leopold saved two. From this, I think we should all endeavor to give such cases the chance that operative treatment holds out. Many of them are hopeless, but even the most skilled prognosis is sometimes at fault, and it is not the duty of any man in such emergencies to fold his hands and say the case is hopeless, the woman must be left to die.—*Edinburgh Medical Journal.*

THE TREATMENT OF CYSTITIS IN WOMEN.—Dr. T. M. Madden presented the following note at the recent International Medical Congress: Of all the diseases which come before us in gynæcological practice there is none more frequently met with, more distressing in its effects, or more intractable to the means generally relied on for its relief, than cystitis in women. I therefore desire to bring under the notice of the International Medical Congress a method of treatment which I have found, by clinical experience, to be generally successful in the rapid curative treatment of this condition. The measures most commonly employed in such cases are merely palliative, and may relieve, but *per se* can never cure, well established cystitis in women. Nor am I aware of any method by which that can be accomplished save by giving the bladder absolute physicological rest. For this purpose, Dr. Emmet's operation—*i.e.*, the establishment of an artificial vesico-vaginal fistula—may be successfully employed in some instances, but the practical objections to it are so great and obvious that for several years past I have abandoned this procedure in favor of an other which I have found more generally effectual and quite free from the disadvantages of the operation referred to. The plan which I have now employed in a very large number of cases

of cystitis in the gynæcological wards of the Mater Misericordiæ Hospital, Dublin, consists firstly in the full dilatation of the urethral canal with the instrument exhibited, so as to paralyze the contractility of the sphincter vesicæ, and thus produce a temporary incontinence of urine; and, secondly, in the direct application through the same instrument of glycerin of carbolic acid to the diseased endovesical mucous membrane. I may add that any pain thus caused may be prevented by the previous topical application of a solution of cocaine, and that the procedure recommended seldom requires to be repeated more than once or twice at intervals of a week or ten days; and, combined with the internal use of boric acid, raely fails to effect a cure in any ordinary case of cystitis.—*New York Med. Jour.*

"TWIN PREGNANCY — HYDRAMNIOS — TAPPING — CURE." PHOCAS, LILLE.—*Annales de Gynécologie, et d'Obstétrique*, May, 1890.

Hydramnios is said to be a rare affection, and its diagnosis is often embarrassing. The symptoms of pregnancy may be masked by the development of the amniotic liquid, and the case present all the characters of a monocystic tumor of the ovary. Incidental reference is made to a case under the care of Tillaux, in which the only sign which made exact diagnosis possible was the slight rhythmical contractions of the uterus. The author's case was that of a woman who had hitherto been always healthy. She had gone through three normal labors, the last about ten months before she came under the care of Phocas. It was eight months since she menstruated, and she believed herself to be pregnant, the movements of the child having been felt about four months after the arrest of menstruation. When everything appeared to be normal, the woman's abdomen suddenly began to enlarge rapidly. Her legs began to swell, and she experienced difficulty in breathing. When Phocas saw her, about three weeks after the first symptoms were observed, he found her emaciated and pale, with drawn features. Her respiration was embarrassed, and the legs were swollen. The abdomen was enormously distended, and apparently more so to the right than to the left. The skin was stretched, and its venation marked. The distance between pubes and umbilicus was greater than between umbilicus and xiphoid cartilage. The tumor extended to behind the lower end of the sternum, and its superior boundary could not be mapped out because of the tenseness of the skin. The tumor was of uniform consistence, it was slightly depressible, and no fœtal parts could be made out. Percussion elicited a dull note everywhere except just below the xiphoid cartilage and in the flanks, and these limits persisted after changing the patient's position; nothing was learned by auscultation, no fœtal movement, no souffle; the os was partially dilated, and movements of the vaginal portion appeared to be conveyed to some extent to the tumor. The diagnosis hesitated between simple cyst of the ovary and hydramnios, with a leaning towards the former, in spite of the signs of pregnancy enumerated. It was resolved to tap. While the fluid was being drawn off, a distinct intermittent hardening was felt in the tumor, and this hardening coincided with an arrest of the flow through the trocar. "The uterus alone could be the seat of such contractions; my trocar was in the womb. I evacuated about four litres of the fluid, and let the rest remain. The patient was greatly relieved. So much was her condition ameliorated that I had all the trouble in the world to make her stay in bed for three days." Five weeks later the patient was delivered of twins—one living, and one that had been dead for some time. Among his other reflections on the case, Phocas is disposed to conclude that tapping is the best treatment for hydramnios.

"EXPERIMENT WITH A SUBSTITUTE FOR THE INDUCTION OF PREMATURE LABOR." PROCHOWNICK, HAMBURG.—*Centralblatt für Gynakologie*, No. 33, 1889.

Considering the danger to the mother involved still in the methods of bringing on labor, and the uncertain prospects both as regards the life and the health of the child, Prochownick resolved to try an experiment by dieting in a suitable case, about which he was consulted in 1887. The woman had been confined already four times—once with perforation, once with turning, and twice by induction of labor prematurely. The children had all died.

She expected to be confined for the fifth time between the 18th and the 22nd of September, 1887. She was put upon special diet on the 1st of August. She was confined on the 20th of September, The child, a female, weighed 2,350 grammes, and was 50½ cm. long. It had all the characters of a mature child, except that it was very lean. It was fed by bottle, and it developed like a mature child, increasing in weight 250–280 grammes per week. The child is still alive and healthy.

Two other cases of more recent occurrence are also detailed. The first of these was the wife of an operative. She was delivered for the first time, in 1875, by cephalotripsy, after futile efforts with the forceps. In 1878 she was again delivered by turning and extraction. The child, which had been in a transverse position, lived only a few hours. In 1884, induction of premature labor, child surviving five weeks. Again expected confinement in first week of January, 1889. Diet very strictly adhered to from the 22nd November preceding. The child was born without obstetric interference. It presented all the signs of maturity, but in proportion to its length it was very thin and devoid of fat. It thrived surprisingly well (*erstaunlich*), and in six weeks weighed 4,000 grammes, at birth 2,800.

The third case gives a somewhat similar history. The child was 52 cm. long at birth, but was extremely thin (*fast durr*).

The principal effect of the regulated diet upon the fœtus was found to be absence of fat. The cranial bones yielded in a remarkable manner.

The diet was as follows:—In the morning, a small cup of coffee and about an ounce of biscuit; in the middle of the day, any kind of flesh meat, eggs and fish, with a small quantity of sauce, some green vegetables, and fat, suitably prepared, salad, cheese. In the evening the same as mid-day, with the addition of two ounces of bread, with butter according to taste of patient. Each patient was allowed half-a-pint or more of red or Moselle wine per day. Water, soup, potatoes, puddings, sugar, and beer, were absolutely forbidden.

"A CONTRIBUTION TO PROCHOWNICK'S SUBSTITUTE FOR INDUCTION OF PREMATURE LABOR." SWIECICKI, POSEN.—*Wiener medizinische Blatter*, May 29th, 1890.

Some reference is made to papers in which the danger of premature labor, especially to the child, is brought out. In Wyder's collected cases, the mortality of the children was 45.3 per cent. and of the mothers 5.3 per cent. So unsatisfactory are the results that some, among whom is Strauch, of Moscow, recommend Cæsarean section in preference to induction of labor. Swiecicki has tried Prochownick's plan and gives a report of four cases, which are somewhat similar in their details. The first was that of a woman of 32, a III. para. Her first labor was completed by the forceps, child still-born. The second ended with craniotomy. In the last eight weeks of her third pregnancy she submitted to Prochownick's dietary, and she gave birth to a living child. The child was very lean, with wrinkled skin, and very movable cranial bones, but it thrives very well.

In all the four cases the results were considered satisfactory, and on the basis of these results the opinion is expressed that in the medium degrees of pelvic deformity the dietetic method promises to be useful. The conservative Cæsarean section should be reserved for the more extreme degrees of pelvic deformity. —*W. J. Sinclair in Med. Chronicle.*

A NEW AND RAPID TEST OF SUGAR.—At a meeting of the Austrian Surgical Society last week, Professor Nothnagel showed a handy test of sugar, which had been forwarded to him by Dr. Becker, of Cairo. It is simply a visiting card saturated with a solution of potash, over part of which is drawn a covering of the sulphate of copper, and the urine applied. The card is then laid on the globe of a lamp, when the saccharine urine will color the card brown, and this color will be the deeper the greater the amount of sugar.—*British and Colonial Druggist.*

VERATRUM VIRIDE IN PUERPERAL CONVULSIONS.—The President, Dr. Parker, at the recent meeting of the Academy of Medicine, Richmond, Va., reported having used in a case of puerperal convulsions, occuring two or three weeks before the expected time of labor (besides the usual plan of venesection and chloroform), tincture of veratrum viride, administering

fourteen drops early, and afterward five drops every two hours. Dr. Hugh M. Taylor, in consultation, had recommended enemata of bromide of potasium and hydrate of chloral in large doses. This was successful in relieving, but labor commenced two or three days afterward, and under chloroform the patient gave birth to a live-child of eight months' gestation, large but feeble. The speaker had great faith in veratrum viride for the relief of convulsions. Mr. Albert Sneed had recommended it in ten-drop doses every two hours.—*N. Y. Med. Jour.*

THE
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS OF THE MEDICAL SCIENCES.

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.

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TORONTO, OCTOBER 1, 1890.

OUR MEDICAL COLLEGES.

The work for the session of 1890-91 is about to commence in our medical colleges. We think there can be no doubt that the value of the work done in the schools is increasing from year to year. If we look back a few years, we will find that the improvement is marked. Great advances have been made in the practical character of the teaching. The students are required to spend more time in the laboratories, the dissecting rooms, and in the hospitals. We are commencing to realize the fact that mere didactic teaching is not sufficient for the wants of our students, and that such instruction, excellent though it may be in its way, must be supplemented by practical work.

The Ontario Medical Council has shown its appreciation of the condition of things by demanding a large proportion of laboratory and bedside teaching. It is far in advance of the average requirements of the United States in insisting on attendance on four full sessions of six months, and one summer session of three months. Many of the American States consider that they are doing well in making an attendance on their full courses of six months compulsory. When we consider that a large proportion of the medical institutions of the United States were accepting a two years' course, with an additional year in the office of a regular practitioner, we must acknowledge that this is a step in advance. While we realize the importance of this new departure, we cannot help feeling that the condition of things medical in the United States of America is very unsatisfactory. In a large proportion of cases there is little or no preliminary education required, and the courses given are very superficial.

Toronto has become a great educational centre. We recognize this fact in connection with medicine quite as much as in other departments. We have three medical colleges, two male and one female, that are doing excellent work. They are increasing in efficiency from year to year. Their equipments are well up to the times. The energy and ability of the several faculties are well known. There is no disposition to stand still; on the other hand, the general desire is to advance. The facilities placed at the disposal of the students are vastly superior to those in times past. There is, however, still room for improvement. We are glad that our teachers fully appreciate this fact. Many of them have carefully studied the methods employed in the best educational institutions of the old world, and are filled with a laudable ambition to give courses fully equal to the best. We are inclined to think that they will succeed.

At the present time appearances indicate a large attendance at all our schools during the coming session. We cannot view the prospect with unmixed gratification. The profession is now sadly over-crowded. What will become of the vast army of new graduates, is a problem we will not attempt to solve. We can scarcely exclude the new aspirants for medical fame. We have no right to try to shut them out, but we certainly ought to make the standard sufficiently high to close the doors against the ignorant and incompetent. We believe that this is being done, and we rejoice at the fact. With these facts in view, we have to congratulate our Canadian medical colleges on their success; and we desire to express the hope that they will each and all endeavor to raise the standard, by their teaching, in all respects.

THE JOHNS HOPKINS HOSPITAL.

Every physician should visit the Johns Hopkins Hospital of Baltimore. Its history is fairly well known, but its wonderful facilities cannot be fully appreciated until one has made a careful inspection of the institution. The trustees received about six millions of dollars, three to be expended on the hospital, and three on the university. One of the conditions is that the principal must not be touched, but only the interest. About two millions have been expended on the hospital up to the present time. There are four professors: Dr. Osler in medicine; Dr. Welch in pathology, including bacteriology; Dr. Halsted in surgery; and Dr. Kelly in gynæcology. There are qualified assistants in connection with each of these departments; and, altogether, the combined staff have charge of all the in and out-door patients.

The dispensary for out-patients is all that could be desired, and the numbers that attend it daily are large. The courses hitherto given are intended solely for graduates, and in all departments there is an immense amount of original investigation continuously going on.

We heard a good deal some time ago about certain losses connected with the investments. These losses were confined to the university, and did cause a certain amount of embarrassment for a time. During a recent visit to the university, we were glad to hear that any anxiety from such a source is entirely removed. A large sum of money was invested in certain railway bonds which, for a time, yielded no revenue. This was a serious matter for an institution which depended entirely upon its revenue exclusive of capital. The trustees showed great wisdom during the temporary loss of income, and simply delayed certain contemplated expenditures. While the cloud was passing over them, they had the good fortune to receive gifts amounting to half a million dollars, which added a silver lining so effectual that they were far removed from despair. The railway bonds were recently sold at a small premium, so that up to the present not a dollar of the principal has been lost. Johns Hopkins stands to-day without the shadow of a cloud hovering over it. The donor and trustees have shown a marvellous sagacity. The hospital is in many respects unique—nothing like it, in all respects, exists in the world. Its laboratories cannot, with our present light, be excelled. Its staff of physicians and teachers is composed of men—young, able, active, and energetic. It is doing a grand and noble work. As a post-graduate university, it stands almost without a rival; and, as far as we can see, is likely to remain so for a long time to come.

THE PROTESTANT HOSPITAL FOR INSANE IN MONTREAL.

We learn from the *Montreal Medical Journal* that this Hospital has been formally opened, and that thirty persons were admitted up to the end of August. It will be remembered that Dr. Burgess, so well and so favorably known in Ontario, was appointed superintendent. He is now in charge of the institution. The Montreal journal expresses the hope that "in a year or so it will rank among the foremost of our American asylums, for the beauty of its surroundings and the good results accomplished."

Meeting of Medical Societies.

CANADIAN MEDICAL ASSOCIATION.

The meeting of the Canadian Medical Association was held at Toronto, on the 9th, 10th, and 11th September. On Tuesday, September 9th, at 10:30 a.m., Dr. James Ross, of Toronto, President of the Association, took the chair, and called the meeting to order. The minutes of the last meeting, held at Banff, were read, and after other routine business, the meeting adjourned.

AFTERNOON SESSION.

The President read his address. He referred briefly to the past history of the Society, and made special allusion to the success of the meeting held at Banff last summer. He then reviewed the history of medicine, noting many of the advances which have been made in medical science from the time of the discovery of the circulation of the blood by Harvey, up to the present time. The President then discussed the subject of Lodge Practice, condemning it, and stating that a doctor appointed to any lodge or company should be paid a fair fee for all services rendered, and that each visit should be charged as in

ordinary practice; the present system is pernicious, and should be entirely stamped out. The one portal system of admitting into the practice of the profession in Canada was advocated; a common standard of proficiency should be demanded by all the provinces of the Dominion, and thus, a man qualified to practice in any one of the provinces, would be free to settle anywhere in Canada; if this end were attained, then we would be in a position to solicit reciprocity with Britain, and our graduates might be entitled to practice there, or anywhere in her Majesty's dominions.

Hon. G. W. Ross, Minister of Education, welcomed the visiting members of the Association to our city, and was glad to be able to place the hall in which the meetings were held at the disposal of the Association.

Dr. Prevost, of Ottawa, then delivered the

ADDRESS IN MEDICINE.

He reviewed the recent advances which have been made in medical science in various departments, more particularly in bacteriology. We can now study pathogeny, the origin of disease. We know that infection is due to the agency of living organisms. To Pasteur is due the development of the study of bacteriology; he taught us that fermentation depends on the presence of germs and that certain pathological phenomena are due to germs. These organisms we can study, cultivate, tame (*i.e.*, "attenuation"), and we can inoculate animals. The attenuation of virus is one of the greatest advances of the century. The question of the possibility of spontaneous generation has been studied in order to discover the origin of germs. Pasteur has successfully demonstrated that germs are diffused in air, and await merely favorable circumstances to develop. What prevents their development in living tissue? Immunity consists in the integrity of the organism attacked. The cutaneous or mucous surface acts as a defence, but introduce the germs through the surface and there follows congestion of the tissues invaded; the white blood corpuscles then take up the microbes and destroy them. Not only do the blood-cells, but cells in various organs of the body, possess this power of destroying microbes —phagocytosis, as the process is called. Shreds of a septic ligature even may be invaded by leucocytes and rendered harmless by their power of destroying the germs. We find that germs exist in the alimentary canal, and there live as parasites, but we escape poison because the organism is always fighting them; they are excreted by the kidneys, many are destroyed in the liver, and oxidation completes the process. Surgery was first to profit by the promulgation of the germ theory, as evidenced by the introduction of antiseptics by Lister and the subsequent advances in various branches of surgical practice, especially in joint-surgery. In medicine we find that bacteriological investigation has, in many cases, cleared up the etiology of disease: contagion is now understood, and preventive treatment has saved many lives. We find that typhoid contagion can be carried in water; pneumonia is infective, and therefore may be epidemic in character. Diphtheria is now known to be at first a purely local disease, and should at the start be attacked locally. The part played by micro-organisms has been demonstrated in such diseases as tuberculosis, leprosy, osteomyelitis, gonorrhœa, etc.

In the future we must carry on our investigations with the view of discovering the agents capable of combating particular germs; we already employ specific remedies for certain diseases, *e.g.*, mercury in syphilis, quinine in malaria, salicylic acid in rheumatism; and the success of the specific treatment is, in all probability, due to the effect of the agent in destroying the virus. We learn also from our studies that the soil must be rendered inert, and this leads us to investigate the hygienic surroundings of the individual.

Sir James Grant complimented Dr. Prevost on the interesting paper he had read. The Association then divided into sections.

THE SURGICAL SECTION.

Dr. Rogers, Montreal, President; Dr. Cowan, Secretary.

Sir James Grant read a paper on

PERI-URETHRAL CELLULITIS.

Two varieties recognized, one of which occurs in isolated patches of small size, about the penile portion of the urethra; and a second, forming a continuous mass between the layers of the triangular ligament behind the bulb.

The case was noted of a man aged forty, who suffered from extravasation of urine, in Feb., 1879; he had had a stricture for some years, the sequel to a gonorrhœa; the symptoms were urgent. Free incisions were made in the perineum, and linseed poultices applied, with great relief to the patient; it was found impossible to pass a catheter. A large portion of the integument of the scrotum sloughed. An opening three-quarters of an inch in length into the membranous portion of the urethra was the result, and urine flowed freely through the perineal fistula. The system was well supported by liberal diet and tonics. The sloughs gradually separated, and were replaced by granulation tissue. The question was, how best to close the fistulous opening; the poultices were continued until the granulation tissue was sufficient to cover the opening, and hide it from view. A number seven elastic catheter was passed into the urethra, entered slowly through the pouting granulations, and almost unexpectedly reached the bladder, the flow of urine through the instrument being quite free; it was retained in situ, and no urine escaped through the fistulous opening. The surface of the granulations was several times brushed over with mild solution of nitrate of silver. At the end of the third day the catheter was removed, and the urine subsequently flowed only through the natural channel. Healing rapidly occurred in the perineum, and in three months the patient resumed his work. The case was cited to demonstrate the marvellous reparative power of granulation tissue, even under the most adverse circumstances.

Dr. Shepherd would have employed different treatment in such a case; he would have performed perineal section at the time to prevent further extravasation. Further, he did not think that three days was sufficient time for healing to take place in an old standing fistula; a recent case, however, might have healed immediately. He considered Dr. Grant very fortunate in the result he obtained.

Dr. J. F. W. Ross then read a paper entitled

THE FAILURE OF THE REMOVAL OF THE OVARIES AND TUBES TO RELIEVE SYMPTOMS.

(This paper will be published in a subsequent issue of the CANADIAN PRACTITIONER.)

Dr. Halford Walker objected to the term "castration in women," and preferred speaking of the "removal of the uterine appendages."

Dr. Shepherd thought that patients are frequently lead to submit to operation without being informed of the serious nature of the procedure.

Dr. Ross replied.

Dr. Shepherd, of Montreal, then read a paper on a case of

CHOLECYSTOTOMY.

After giving a short account of the history of the operation, and the difficulties attending it, especially when the gall-bladder was small and shrunken or altered by inflammatory action, he related a case in which the operation had been successfully performed. The patient was a lady, aged fifty-one, who had been suffering from dyspeptic symptoms, with pain in the epigastrium for a year, and had been losing flesh. Some six weeks before she consulted Dr. Shepherd, she had had several severe attacks of excessive pain in the abdomen, with incessant vomiting, great tenderness, with high temperature. At this time her medical attendant noticed a tumor to the right of the umbilicus. This tumor was apparently about the size of a fœtal head, to the right and over-lapping the median line below the umbilicus; it was freely movable, dull on percussion, and tender It appeared to be smooth on the surface, and deeper down, hard and irregular. Patient had never had jaundice or attacks of hepatic colic. The growth was thought to be malignant, and probably connected with the bowel. An exploratory incision was advised, to which patient willingly consented. Operation was performed on June 17th, 1890. On coming down on the mass it was found to be an elongated portion of liver, and beneath this was a large hard mass, covered over by omentum and intestine, and looking like new growth. On separating this elongated portion of tissue from the mass, there was some hemorrhage and an escape of dark colored fluid; on introducing his finger, Dr. Shepherd felt a substance which, on removal with forceps, proved to be a large gall-stone; on introducing his finger still further, a constriction was met with; and beyond this, a cavity containing another large stone; this was extracted with difficulty. The edges of the cavity which had contained the gall-stones were so friable that they could not be brought to the abdominal walls. However, after some trouble

and by making use of liver and omentum, the space between the edges of the gall-bladder and the abdominal parietes was filled up, a drainage-tube introduced, the elongated lobe of the liver replaced, and the abdominal wound closed. The patient recovered rapidly, without any elevation of temperature or rise of pulse. Bile flowed freely from the wound for some days. The tube was removed on the fifth day, and bile ceased to flow on the fifteenth day after operation. At the end of the second week the patient went out driving every day, and has since been perfectly well. Dr. Shepherd stated that owing to the pressure of the ribs on the right lobe of the liver a true "lacing lobe" had been formed, the gall-bladder being entirely in this portion of the liver; the thinnest part of liver was directly over the neck of the gall-bladder and cystic duct, which produced stagnation of the flow of bile, and hence its thickening and the formation of gall-stones. The difficulties in the diagnosis of the case, even after the abdomen was opened, were alluded to, and the case was cited as an example of the advantage of exploratory incision, even in doubtful and apparently hopeless cases.

Dr. Chown, Winnipeg, cited a case of long-standing jaundice, where an exploratory incision was made. The pancreas was found irregularly enlarged, and by direct pressure shutting up the common bile duct. The gall-bladder was pushed to the right; the central incision was closed, and a second one made over the gall-bladder, on the right; the bladder was sewn to the edges of the incision by continuous suture; it was then opened and three ounces of bile removed; since the operation, the patient has passed all the bile through the fistulous opening. Six weeks have now passed, and there is no difficulty in keeping the fistula open. The jaundice is relieved; the tumor still exists, and therefore the relief is of a temporary character.

Dr. Oldright asked the indications for the operation of cholecystotomy.

Dr. Praeger, of British Columbia, narrated a case where there was enormous distention of the gall-bladder. Cholecystotomy was done with good results.

Dr. J. F. W. Ross asked if the continuous suture was necessary in Dr. Shepherd's case—adhesions form rapidly, and if the tube is kept clear for a short time, would adhesions not form and do away with the necessity of the suture?

Dr. Bell, Montreal, referred to the great difficulty in arriving at a diagnosis in these conditions. Dr. Bell thinks that sometimes a gall-stone may ulcerate through the intestine, and pass per rectum; he recorded a case where this probably occurred; the stone was an inch in its smallest diameter, and it was impossible for it to have come through the duct.

Dr. Shepherd replied.

THE MEDICAL SECTION.

Dr. McPhedran, Toronto, in the chair; Dr. F. G. Finley, Montreal, Secretary.

Dr. R. L. MacDonnell, Montreal, read a paper entitled

CARDIAC COMPLICATIONS OF GONORRHŒAL RHEUMATISM,

in which he reviewed the literature of the subject from its earliest mention, by Braude, in 1853, up to the present date, and criticized some of the reports put on record. The case books of the Montreal General Hospital, from the time of his connection with the institution to date, furnished twenty-seven cases of gonorrhœal rheumatism; of these there were six cases in which cardiac physical signs were present, but in three of these a history of rheumatism or scarlet fever could not be excluded. Two others had undoubted gonorrhœal rheumatism, and heart murmurs were found when the patients were admitted. In the sixth case cardiac symptoms were present at the outset. The patient, who was suffering from a gonorrhœa, was exposed to cold. Slight joint pains were present, followed by urgent dyspnœa and pericarditis. Endocarditis and pleuritis subsequently.

Dr. Graham, of Toronto, was not prepared to accept the possibility of a connection between gonorrhœal rheumatism and cardiac affections. He was inclined to think that Dr. MacDonnell's case was merely acute rheumatism, with heart complications occurring in a man who had gonorrhœa, and he pointed out that the trivial nature of the joint pains supported this theory. An old endocarditis might be again set in action by a recent gonorrhœa.

Dr. R. L. MacDonnell said, in replying to the criticism of his paper, that cases were on record where the joint pains were absent altogether,

the endocarditis occurring suddenly in the course of a gonorrhœa.

Dr. Nesbitt read a paper on the

PHARMACOLOGY OF SALICYLAMIDE.

Dr. Stewart, of Montreal, spoke in high terms of the energy and industry of the reader, in carrying out scientific investigation with such a good result.

Dr. F. G. Finley, of Montreal, read a paper on

SPINAL SYPHISIS.

After referring to the pathology of the disease in general, and the variety of forms it may assume in the spinal cord, he read the histories of two cases he had had under observation recently. In one a gumma probably pressed upon the cord, and the symptoms rapidly yielded to the administration of mercury. The second case was probably of the nature of a myelitis, and had been but slightly influenced by treatment.

Wednesday, Sept. 10th.

Dr. Chown, Winnipeg, read a paper on

HYDATID TUMORS.

He referred briefly to the life history of tænia echinococcus, and of the manner in which the larval stage was accountable for the formation of the hydatid growths. These growths may occur in any part of the body, but are most frequently met with in the liver; then we find them in the peritoneum, the lungs, the brain, or in the muscles. The mode of development of the hydatid cyst was explained; the formation of the outer firm fibrous capsule, lined by the mother sac, from which daughter cysts were developed; sometimes even a third or fourth generation appeared. The sac increases in size according to the number of cysts and the quantity of fluid contained. The heads of the tænia echinococcus may be found in various stages of development. The fluid has a specific gravity of about 1013, is neutral or slightly alkaline, contains chloride of sodium, but no albumen. It is usually clear, but may be rendered turbid when a large number of heads of the tænia echinococcus is present. The symptoms of these growths depend on their size and position. We may have secondary trouble, such as jaundice, ascites, anasarca, or paroxysmal pains, œdema, varicose veins, etc.; if in the lungs, we have dyspnœa, cough, or even hæmoptysis; if in the abdomen, we may have anorexia or vomiting, and pain after eating. Cysts may undergo changes of various kinds, *e.g.*, calcareous degeneration, absorption of fluid and caseation or suppuration. Rupture may occur into the bronchi, bladder or uterus, or it may occur into the peritoneal cavity, and cause death. Occasionally it ruptures into the intestine.

The diagnosis is often impossible without an exploratory operation. Hydatid fremitus is rarely obtained; it is supposed to be due to the rubbing of one daughter cyst upon another; it is only after long experience that one can learn to recognize it, and is of very litttle diagnostic value; the microscopic examination of the fluid will help one to distinguish from urine, from the contents of an ovarian cyst, and other fluids.

The methods of treatment spoken of were: (1) Electrolysis, (2) puncture and drainage, (3) incision, and (4) excision. Puncture and drainage is the commonest method of treating these growths—the contents are withdrawn, and the cyst collapses; this is followed by free exudation into the cyst, which, however, absorbs readily. There is no danger if the operation is performed with antiseptic precautions. The indications for this form of treatment are, when the tumor is of moderate size, and in some of those tumors situated in the liver, lungs, or spleen: incision is performed when the tumor is situated within the peritoneum; after securing adhesions the tumor is freely incised; this is necessary in those growths in which there are many daughter cysts. Enucleation is necessary in some cases.

Dr. Chown narrated the history of a case where a large number of cysts existed in a man thirty years of age; sixteen separate cysts were removed from different parts of the abdominal cavity.

Dr. Cameron, of Montreal, then read a paper on

THE TEMPERATURE OF THE PUERPERAL PATIENT.

At the beginning of labor the temperature is normal, but it rises as labor progresses; it rises higher in primiparae than in multiparae. It varies with the length and severity of labor. During the first twelve hours after labor there is a rise; during the next twelve hours the temperature gradually falls. In births occurring from 5 a.m. to 2 p.m., the highest temperature is reached; in births from 2 to 6 p.m., the tem-

perature does not rise so high; and in births from 6 p.m. to 4 a.m., the rise is very slight. Therefore, in general, in births during the night there is little or no rise; and in births during the day the rise is marked. These variations are within the normal range; the proportion of non-febrile cases in midwifery should be about 80%. As a cause of febrile symptoms, "milk fever" is often spoken of, but it has been proved over and over again that lactation is physiological, and there should be no rise in temperature during the establishment of lactation. There may be a slight temporary rise in an excitable patient when the breast fills rapidly, but this is transitory. There is many a tale told by the old-fashioned nurse of the dire consequences when the milk reaches the brain, etc. The causes may be grouped under the headings of infectious and non-infectious. Of the infectious causes we have (1) wound infection; a poison may be introduced through lacerations in the parturient canals; this may be benign or malignant, depending on the virulence or amount of the organisms, or upon the resisting power of the body tissues. Clots may lie in the genital tract, and may there become infected. Micro-organisms are always introduced from without; if the term "anto-infection" means spontaneous infection, then there can be no such thing. We may have developed vulvitis, endometritis, cellulitis, lymphangitis, peritonitis, phlebitis, arthritis, or acute septicæmia, in all of these the temperature rises rapidly. (2) Dormant tendencies may be roused into activity, *e.g.*, an exacerbation in phthisis, pneumonia, or bronchitis; or some one of the exanthema, malaria, or diphtheria, may have been incubating, and may be precipitated by labor. (3) Cystitis may develop; or (4) skin affections.

Of the non-infectious group of cases, we have (1) emotional, profound physical disturbances, *e.g.*, grief, illegitimate labors, etc. (2) Exposure to cold. (3) Reflex irritation, digestive derangements, *e.g.*, constipation.

Thus a high temperature in a lying-in woman may be serious or not serious; we are apt to think of what we most dread, and to suspect septicæmia when the temperature rises.

The lessons we learn from a consideration of these points are (1) the necessity for antiseptic measures throughout, thorough in detail. We must prepare the field by washing the vulva with 1-1000 perchloride of mercury; in the second stage we may use a prophylactic douche if there be a leucorrhœal discharge; disinfect hands, instruments, etc., and use no sponges; vaginal examination should be made as seldom as possible; douche immediately after a prolonged vaginal examination; examine carefully for lacerations after the child is born, and carefully close up any wounds with suture, after cleansing with an antiseptic; thorough cleanliness and antiseptic precautions throughout the puerperium; corrosive sublimate is the best antiseptic. If a man carries out antiseptic details, and a rise of temperature occurs, he need not take alarm, as it is, under these circumstances, in all probability, due to a non-infectious cause.

In the discussion which followed Dr. Cameron's paper, Dr. Sweetnam referred to a cause of a rise of temperature not referred to in the paper, namely, an abrasion of the breast where infection occurred; he narrated two cases.

Dr. Mullin, of Hamilton, believes that there is a particular cause for each case of puerperal fever, and the attendants are responsible. It is a question whether or not the "non-infectious" causes put forward to explain the rise in temperature are not merely produced to account for mild cases of septicæmia, in which our antiseptic measures have failed. One important means of preventing the condition is to remove all elements capable of becoming infected, *e.g.*, clots in the vagina, and preserve scrupulous cleanliness.

Dr. Praeger, of British Columbia, stated that the use of antiseptics had certainly not added to the mortality, and, therefore, if its efficiency be even a mere matter of doubt, we should give our patients the benefit of that doubt, and use antiseptics. He narrated an experience he had some years ago where, during a scarlet fever epidemic, he was unable, although observing scrupulous cleanliness, to prevent puerperal fever in his lying-in patients. Recently, however, during an epidemic of diphtheria, where he attended diphtheritic patients and confinement cases, he was enabled, through the use of antiseptic precautions, as well as the observation of cleanliness to prevent septic infection in any one of his cases.

The discussion was further taken part in by Drs. Sloan, of Blyth; Dickson, of Pembroke; Lap-

thorn Smith, of Montreal; Gardiner, of London; Armstrong, of Montreal; and Dixon, of Toronto.

Dr. Cameron replied.

Wednesday evening.

Dr. Muir read the address in

MATERIA MEDICA AND THERAPEUTICS.

He first called attention to the fact that the majority of practitioners neglected the study of materia medica, and were not as conversant with the subject as they ought to be. The adulteration of drugs was spoken of, and quotations made from the pharmaceutical report of New York State, and Rusby's report on the action of drugs. Dr. Muir then reviewed the work recently done in the investigation of the action of certain drugs, especially in the groups of antipyretics and heart tonics, and then referred to some of the newer drugs—exalgine, ural, thyol, icthyol, thyol-resorcin, and chloramid. Last of all he discussed the anæsthetic, chloroform, ether, and cocaine. Cocaine poisoning was spoken of as a serious result of the careless use of the drug; toxic effects are very apt to follow even small doses; especially if used about the mouth and head.

Dr. Bell, of Montreal, differs from Dr. Muir, and considers that chloroform is a more dangerous anæsthetic than ether. Dr. Bell uses ether as a general anæsthetic, and gives chloroform only in special cases, *e.g.*, in children, in cases where there is disease of the blood-vessels, or in tubercular disease.

Dr. McPhedran condemns the promiscuous use of antipyrin by the public there is, he considers, much danger in the prostration produced by it. He has found no benefit from it in diabetes. Creasote in phthisis is good in certain cases; it is no good in the acute disease, but acts better in chronic phthisis, particularly in males; large doses must be given.

Dr. English, of London, also took part in the discussion.

Dr. McPhedran, of Toronto, read a paper on

PERNICIOUS ANÆMIA.

He recorded five cases of this disease. In the first a physician, there was a history of failing health with anæmia for three or four years. Continued practice until April, 1889. When first seen on May 1st, he had just had a severe chill; the temperature was 104°. He was semi-conscious and delirious. Pallor extreme, with marked, yellow-greenish tint; conjunctiva pearly. Not emaciated. There was vomiting and diarrhœa, with much painful flatulence. The blood contained 745,000 red corpuscles per c. mill., instead of the normal 5,000,000, the characters of the corpuscles being those typical of pernicious anæmia. The urine was of normal amount, acid, very high-colored, and low sp. gr., no albumen. As soon as the stomach quieted, arsenic was given, gr. ¼, daily, in divided doses every two hours. There was not much change for two weeks, after which he improved gradually. He was able to walk out in June, and returned home early in July, up to which time he had continued the arsenic regularly; its use was intermitted after that. He regained his health fully by October, and has since continued well.

Case 2.—Had a long history of failing health also. He had no acute symptoms; his condition was typical of pernicious anæmia. The blood contained only 606,000 corpuscles per c. mill. He could take arsenic only a few days until pain was caused in the stomach. It was intermitted until the pain abated, when the arsenic was given again, to be intermitted when the pain became troublesome. He improved slowly, often relapsing. His urine had the characters described in case 1. He made a complete recovery in eight months.

Case 3.—A lady, after the birth of her second child, showed marked and increasing anæmia, with gradual development of the "lemon" tint; urine dark, and low sp. gr.; blood typical. Made a good recovery in six months The cause here was probably an unsanitary condition of the house.

Case 4.—A physician—the anæmia followed *la grippe*. All the symptoms typical. Vomiting was especially prominent, so that malignant disease was suspected. During the exacerbations many casts were found in the urine, heavily loaded with black pigment granules, also much free yellow granular pigment in masses; this pigment disappeared, as the exacerbation abated. No improvement thus far.

Case 5 is now under care. She had a similar attack two years ago, and improved without special treatment.

In all these cases there was some irregular elevation of temperature; pallor, with the "lemon" tint, but without emaciation, high-colored urine of low sp. gr., the characteristic blood changes, and the gastro-intestinal disturbance. The disease appears to consist essentially of excessive blood destruction in the portal system, due to some poison absorbed from the intestinal tract, in which there is probably greatly increased putrefaction going on. What the poison may be is uncertain.

In the treatment of these cases, the bowels should, as far as possible, be kept clear of decomposing matter, and disinfected. In most cases an occasional mild calomel purge will do good, followed by an intestinal disinfectant, such as beta-naphthol gr. 5, or thymol gr. 3, three or four times a day.

Of the first importance, however, is the administration of arsenic; few cases get well without it. It is best given in small doses, say gr. $\frac{1}{10}$, every two or three hours after food. If not well borne, smaller doses, even a half drop of Fowler's solution, should be tried, every hour. Most cases bear it given freely. It probably acts on the blood, rendering the hæmoglobin more difficult of being dissolved out of the corpuscles. When it fails, after being perseveringly tried in all the different methods iron should be tried—it sometimes succeeds. Hydrochloric acid should be useful in preventing decomposition in the stomach, increasing peristalsis and promoting digestion and absorption. The diet should be highly nutritious, consisting of the iron-bearing foods, as yelk of egg, milk, meat, and cereals of all kinds. It is said that these foods increase the blood destruction, so that if a case is not doing well, it would be desirable to confine the patient to the farinaceous, omitting the nitrogenous foods. As all cases of pernicious anæmia are distinguished only after they have lasted some time, it would be well to treat all grave persistent anæmias with arsenic, as it is useful in all kinds. By so doing, some cases of pernicious anæmia might be prevented possibly.

Dr. Stewart, of Montreal, spoke of the treatment of pernicious anæmia with arsenic. He administered it in doses of m. ½, Fowler's solution, every hour, and given in this way it does not cause gastric irritation.

Dr. Graham classified cases of pernicious anæmia, as (1) those cases which prove fatal, (2) those cases amenable to treatment, and (3) those occurring after confinement. The disease is a very obscure one.

Dr. McPhedran replied.

Thursday morning.

Dr. Lapthorn Smith read a paper on

APOSTOLI'S METHOD.

He first of all described the proper way of carrying out the treatment scientifically and efficiently, and spoke of the causes of failure, one cause being that of not applying the positive electrode to the whole of the uterine surface. Sounds are sometimes inefficient, because in many cases there exists several curves in the cavity of the uterus. Dr. Smith has used a flexible bougie, by means of which he has been able to overcome the difficulty. The cause of failure in these cases is that the whole of the bleeding surface is not treated; by means of the flexible bougie, however, this can be done most efficiently. Two cases of failure were narrated, due to the curves in the cavity. A projecting fibroid may cause an extra curve in the uterine cavity.

Dr. Holford Walker then read a paper on the same subject, and narrated several cases which he had treated successfully.

In the discussion which followed, Dr. Walker referred to a case in which Dr. Smith's flexible bougie would have proved of great service to him had he known of the instrument.

Drs. Dickson, of Toronto, Sloane of Blyth, and Henderson, of Kingston, took part in the discussion, and Drs. Smith and Walker replied.

Dr. B. E. MacKenzie, of Toronto, then showed

A CASE OF LATERAL CURVATURE OF THE SPINE.

Boy, 11 years. Five years ago the boy's mother noticed the shoulders and hips not held symmetrically in relation to the spine. There is now a marked dorsal curve to the left, with rotation and lumbar curve to the right.

He has been under treatment six weeks, and under Dr. MacKenzie's supervision takes exercises selected for the purpose of developing such muscles as make greatest correction of the deformity. By an effort it is found that the boy can now almost straighten the spine, and can hold himself so as to measure three-fourths of

an inch more in height than he did six weeks ago. To secure the best results it is essential to secure the hearty co-operation of the patient. It is necessary to insist that the best possible attitude be assumed and maintained throughout, that corrections be made constantly by the surgeon, and by the patient when standing before a large mirror. In this manner the senses of the patient must be assiduously and patiently re-educated. In this case a girdle was employed, secured to the wall by a hook, and passing over the part of the ribs on the left, made prominent by spinal rotation in the dorsal region. While the patient throws his weight upon the girdle, it is seen that he can over-correct the dorsal curve. At the same time strong force is with the surgeon's hands to press inward and forward the prominent angles of the ribs behind, and inward and backward the part of the ribs of the right side opposite, thus correcting the rotation; at night the patient lies upon the cradle so commonly employed.

Such treatment is much more satisfactory than treatment by any form of jacket, which restrains the normal movements and causes atrophy of the muscles intended by nature to hold the spine erect. In very extreme cases of curvature it may be necessary to use supports.

To attain success, it is necessary (1) to give unremitting personal attention for several months. (2) To have the hearty co-operation of the patient—not only the assent, but the positive determined will. (3) To observe the patient in various attitudes, and to study the effects of various exercises, so as to strengthen those groups of muscles which are most effective in retaining the best attitude that can be assumed. (4) To combine intelligently the use of a moulding power upon the deformity, such as by the hands of the surgeon, or by Barwell's girdle.

Dr. H. S. Birkett, of Montreal, read a paper on a case of

HEMIATROPHY OF THE TONGUE.

In this case (a male, æt. 23) there is atrophy of the right half of the tongue; tactile and special sense of taste intact; paralysis of the right side of the soft palate; diminished sensation of the mucous membrane of the buccal and naso-pharynx; very limited movement of abduction and adduction of the right vocal cord; persistent myosis of the right pupil; and when pressure is made upon a small, thickened, and infiltrated area, situated on the right side of the neck, just in front of the anterior border of the sterno-mastoid muscle, and at a level of a line drawn backwards from the angle of the lower jaw on the same side, the effect is to produce marked flushing and sweating of the right side of the face with dryness of the throat—these last named symptoms passing off when the pressure is removed. There never was nor is there any difficulty in deglutition; speech was at first affected, especially for words containing the letter "r"; pulse 98. The cause of the symptoms is the involvement of the hypoglossal, vagus, and accessory nerves of the branches of the pharyngeal plexus, and of the superior cervical ganglia of the cervical sympathetic in cicatricial and inflammatory tissue, the result of a large and painful swelling at the angle of the lower jaw on the right side, which came on during convalescence from an attack of mumps nine years ago.

The deductions are: (1) That the hypoglossal is the motor and trophic nerve of the tongue. (2) That the glosso-pharyngeal nerve is concerned in the function of taste. (3) That the branches of the pharyngeal plexus supply the mucous membrane of the buccal and naso-pharynx with sensation. (4) That the motor nerve of the levator palati and azygos uvulæ muscles is probably the accessorius. (5) That the superior cervical ganglia of the cervical sympathetic contains (*a*) dilator fibres to the iris of the same side, (*b*) vaso-motor (*c*) sweat, (*d*) and special secreting nerve fibres.

Hospital Reports.

A CASE OF UNADMITTED PREGNANCY.

UNDER THE CARE OF DR. J. F. W. ROSS, IN THE TORONTO GENERAL HOSPITAL.

L. T., æt. 26, single. Menstruations began at 20, and have been irregular in their appearance ever since. She has not menstruated for three years. She complained, on admission to the hospital, of a swelling in the abdomen, which she noticed for the first time two years ago; this has gradually increased in size. The abdomen was examined, and the patient was carefully questioned as to the possibility of her being pregnant, but she gave positive assurance

that she was not. The breasts gave no evidence of pregnancy excepting a slight discoloration of the nipple. Careful examination failed to detect any fœtal heart sounds. Vagina showed no discoloration such as is observed in pregnancy, but it was remarked that there was a laxity of the parts as in the pregnant condition. The stethoscope was inserted to detect any placental bruit with negative results. All present excepting the doctor and the nurse now went out of the room, when the patient was again questioned concerning any possibility of her being pregnant; the doctor also warned her that in case she were and did not admit it, what he was now about to do would endanger her life. She still said it was impossible. Those absent now returned. The speculum was introduced. From the appearance of the os uteri the doctor thought she had had a child. This she denied, but said an operation was performed on her three years ago, when a polypus was removed. The sound was next introduced and passed 4½ inches. Further examination was not made. She was asked to come in as an internal patient. She came in on the next day (Friday). On Saturday morning, owing to a mistake being made in names, this patient was being prepared for a serious operation, the mistake was soon noticed, yet the patient was quite willing, without admitting her pregnancy, to be prepared for an operation, the gravity of which she knew. Saturday afternoon the examination of her case was continued. She again said that what she said on Thursday was true. The sound was passed 7½ inches. The os uteri was well dilated. The doctor thought the diagnosis lay between a myoma and pregnancy. To make a better examination the patient was anæsthetized with chloroform. The finger was now inserted in the os, and a diagnosis given as a case of pregnancy. The head, and the hands or feet could be felt. Applied also ballottement. Also heard fœtal heart sounds by pressing well the end of the stethoscope on the abdominal wall.

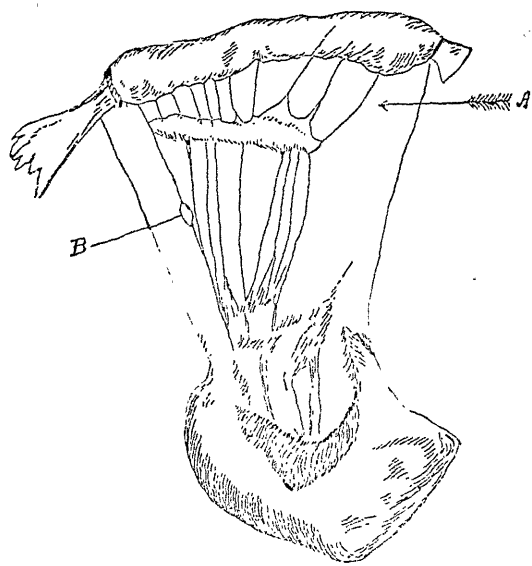
The next International Medical Congress will be held in Rome in 1893.

* Hot claret is said to be an excellent gargle in acute sore throat, being an agreeable astringent and non-poisonous.—*Coll. and Clin. Rec.*

Pathology.

SIMPLE CYSTS OF THE BROAD LIGAMENT.

Dr. Wm. Goodell, of Philadelphia, in his paper on "Intraligamentary Cysts," published in the transactions of the Philadelphia Obstetrical Society, places them in two classes, viz., unilocular papillomatous cysts, and multilocular papillomatous cysts. The unilocular variety he refers for its origin to a so-called degeneration of the parovarium tubules—the multilocular he refers, with Doran, to fœtal relics in the hilum tissue of the ovary, these fœtal relics being the remains of the "mesonephros" or Wolffian body. In addition to the two above



A—Tubules, supposed to be aberrant parovarian tubules, and on which cysts are found. B—Small parovarian cyst.

mentioned forms, Doran and Bland Sutton speak of a third class, which has been denominated "simple cysts" of the broad ligament, and in regard to which both of these authorities have come to the conclusion that they are unconnected with the parovarium. Sutton has further concluded that in some cases, at least, they are formed from lymphatic vessels by dilatation. In support of this view, he describes on page 209 of his "Introduction to General Pathology," a specimen of simple broad ligament cyst, the connexion of which with the lymphatic vessels of the broad ligament was easily demonstrated, since the coagulation of lymph within

the vessels provided him with a natural injection of these channels. In spite of this testimony to the contrary, I would still venture to suggest that some at least of these small, even minute, cysts, which are so frequently found studding the broad ligament, and particularly where the peritoneum is reflected over the Fallopian tube, may be due to dilatation of pre-existing tubules, which are connected with the parovarium. This conclusion has been arrived at after dissection of a considerable number of specimens. A cut of the most perfect of these is presented with these notes.

I would not be understood to say that this mode of origin of these cysts obtains in *all* cases. Facts like those brought forward by Mr. Sutton prove the contrary, but specimens such as represented in the accompanying cut are, to my mind, extremely suggestive. Nor does the fact that in the majority of cases we are unable to show connexion between such a cyst and a tubule seem to invalidate the argument based on this specimen; since if only in *one* instance can the connexion with lymphatics be demonstrated, much more difficulty might reasonably be expected in the case of tubules, which are merely fœtal remains, and only accidentally find their way to such an abnormal situation.

In the specimen presented there is to be seen a series of tubes running from the Wolffian duct upwards towards the Fallopian tube, and apparently connected with the duct, just as are the tubes from Rosenmüller's organ below. The appearance presented is very striking, and has been found in only a single specimen. Another specimen, however, seems to show that one of the segmental tubes of the parovarium is continuous with a short tube running upwards in the same direction as those figured. That the lower tube is parovarium is proven by its position, and the presence on it of a cyst. The most careful dissection could not separate it from the process above running towards the Fallopian tube. That the process above is a similar tubule is shown by the fact that its dimensions are even, and that it ends abruptly. As to how or why such an abnormal disposition of these tubules should come about, I can offer no definite opinion. Possibly the Müllerian duct may have been so placed that, in taking up its position as Fallopian tube, it dragged some of the Wolffian tubules with it.—J.C.

Correspondence.

LETTER FROM DR. J. E. GRAHAM.

Editor of THE CANADIAN PRACTITIONER.

DEAR SIR,—Very great progress has been made in the cause of higher education in France, during the past fifteen years. In 1875 a determined effort was made to place the academies or schools for higher education upon a proper foundation, and the results have been simply marvellous, especially when it is remembered that France was at that time suffering from the effects of a defeat which would have entirely crushed most nations.

Twenty million dollars have been spent on the erection of new buildings. More than half of this amount has been contributed by the cities in which the Universities are situated. It was felt that without generous subscription from the cities, little could have been done in the way of obtaining State aid.

The people of Toronto would do well to profit by her example, and not be niggardly in their donations to the University which does so much for them. The city of Paris gave over five millions for the erection of new buildings, Lyons nearly a million and a half, and Bordeaux over half a million.

It is especially worthy of notice that in these improvements the faculties of medicine have received a share in the same proportion as that of arts or law. The ridiculous idea that public money should not be used in the furtherance of purely professional education, does not prevail in France, nor anywhere else on the Continent for that matter. It is recognized that in medicine a full and comprehensive education cannot be given without outside aid.

For years past the tendency in France has been to centralize the faculties for higher education in Paris. Five-eighths of all the students of France attend the University of that city; and of the 1,192 foreign students more than a thousand are to be found in Paris. In this respect the educational system of France differs widely from that of Germany. In the former country there are no universities to compare with those of Bronn, Gœttingen, Heidelberg, Leipsic, etc.

Efforts have recently been made to give the outside academies, as those of Lyons, Nancy, and Bourdeaux, such advantages as would put them on a similar basis to that of Paris. Whether this movement will be successful or not remains to be seen.

In Germany and Switzerland one is struck by the wonderful development of the universities of the smaller cities. I had the privilege of spending a few days in Lausanne, Geneva, Zurich, and Heidelberg, and of looking somewhat into the educational systems in each of these cities.

In Lausanne the University was not fully equipped until a few years ago, when it received a very large legacy. It now possesses a very good medical faculty. In the University of Geneva there is also a medical faculty. Zurich, however, possesses the most distinguished medical faculty, as well as the best faculties for the study of medicine. The pathological, physiological, and physical laboratories, are very complete, and quite large enough for the class of students in attendance.

The hospital, although small, containing about 150 beds, must be very rich in clinical material. Although daily clinics are given, both in medicine and surgery, there seems to be an abundance of interesting cases.

The course of instruction in the medical department of the German Universities is excellent. In the first place a thorough and practical training is given in the primary branches. A mere book knowledge of these subjects is considered of little use, and nothing short of a laboratory training is demanded. In the final branches the instruction given is of the most practical character. Didactic lectures are largely done away with, and those of a clinical character substituted. Two clinics, of an hour and a-half each, one in medicine and the other in surgery, are given daily.

In Zurich I had the pleasure of hearing Dr. Eichorst give a clinical lecture on two cases: one of floating kidney, and the other of tuberculosis of the kidney.

The patients were both females, and were brought in on their beds. They had a very easy and convenient way of moving the beds from the wards into the lecture room.

In the first case the lecturer wished to demonstrate that the tumor to be felt in the abdomen was not connected with the stomach. To do this he dilated the stomach by giving the patient first a small teaspoonful of sodæ bicarb., followed by one of tartaric acid. The stomach was known to be large, and an œsophageal tube was at hand in case of unpleasant symptoms. The patient was exposed to a much greater extent than is usual in our hospitals, and the rapid increase in size of the abdomen was watched with interest and some amusement by the class. It served, however, the purpose for which it was intended. The second case the lecturer examined very carefully. The history, read by one of the students, was very full, and must have been written after a thorough supervision by either the professor or one of his assistants. The differential diagnosis was then taken up, and the urine was then examined, chemically and microscopically. It was found to contain not only pus, but tubercular bacilli.

In Heidelberg I heard Professor Erb, and was even more astonished at the apparent wealth of material there, although the hospital is a small one.

He first demonstrated the varieties of gait in different nervous affections, and for that purpose exhibited three or four cases of ataxia. Three of hereditary spasmodic tabes, one of pseudo hypertrophic muscular paralysis, two of paralysis of groups of muscles in the legs, two of partial paraplegia from transverse myelitis, and a case of anchylosis of the hip joint.

He afterwards gave a lecture on a case of subacute ascending anterior polio myelitis, combined with some peripheral neuritis, at least that was the diagnosis made. He went thoroughly into the differential diagnosis between these conditions, acute ascending paralysis and multiple neuritis. He also referred to the theory recently promulgated by Dejaiene, that all these are really cases of multiple neuritis. He did not agree with Dejaiene, but at the same time admitted that both conditions were frequently found in the same patient. The lecture was most interesting, and evinced a large amount of work in its preparation.

After visiting these universities, I came to the conclusion that a very large hospital is not necessary in order to give a good course in clinical medicine. There are, however, certain

essential points: (1) The hospital should be so arranged that patients can be easily taken into the theatre without being removed from their beds. This can be done if the lecture-room is on the same flat as the wards. (2) The teaching staff should have full control of the hospital, and each professor should have separate and distinct wards. (3) It is necessary that each lecturer should spend at least three or four hours daily in the hospital, and that each case should be fully elaborated in every particular, before it is brought into the theatre. Thoroughness of examination should be inculcated at all times.

In one respect the German system is not so good as the English, or as that adopted in Toronto. The students are not brought into such immediate contact with the patients, and there is less tutorial instruction given. In the latter particular the Edinburgh school excels all others.

During the week before the commencement of the Congress, I had the privilege of hearing some clinics in the Charite, especially those of Dr. Genhard.

In a former letter I referred to the great number of old men who held the professional chairs in the Paris University, and the same is also noticeable in Berlin.

Professors who have made their mark in the smaller universities, are often called to Berlin at the age of forty-five or fifty, and the effect is that much younger men are found in Heidelberg, Leipsic, etc., than at the capital. The result ought to be in favor of the latter city; only men of ripe experience are found in the university. There is, however, a tendency for older men to become garrulous and to depart very frequently from the subject under consideration. This tendency ought to be fought against, as disconnected remarks and stories of personal experience, although very interesting at the time, are not always of the most advantage to the student. The lectures which I heard in Heidelberg and Zurich were quite free from this; whereas that of Dr. Genhard was partly made up of anecdotes of practice, and the discussion of subjects aside from that under consideration. His lectures, notwithstanding, were most excellent, and gave evidence of a long experience in practice.

The great International Congress of Berlin is now a thing of the past, and, if the truth must be told, there was on the part of many a feeling of disappointment at the results. The very large attendance, the great number of eminent men present, and the character of Berlin as a seat of medical education, all would lead one to expect a most successful gathering.

With all these advantages, it lacked one feature. The place of meeting, although very beautiful, was not adapted for the purpose, and the result was that one could not either hear or see to advantage.

Again, a number of men of great assurance and little brains will persist in occupying time which should be given to the leaders of the profession. If the meetings of section had been held in the University class-rooms, and if there had been some supervision of papers, the results would have been very different.

In all other respects the arrangements were excellent, and the social features all that could be desired. The hospitality of the people of Berlin was unbounded. The Ladies' Committee undertook the entertainment of lady visitors, and most successfully carried out a programme of luncheons, dinners, receptions, etc., for each day.

No one was received with greater enthusiasm than Sir Joseph Lister, who shared with the honored President, Dr. Virchow, the honors at the celebrated Rathhaus banquet.

LODGE PRACTICE.

Editor of CANADIAN PRACTITIONER:

SIR—While agreeing in the main with your editorial remarks in your issue of 16th August, and with those of Dr. McKinnon in that of 1st Sept., allow me to say that exclusion of those who engage in such practice from the Ontario Medical Association, is something they themselves have brought upon themselves, and that with their eyes open. It is not "a drastic measure," as you say, that they were not aware of, would or could be applied, because the Association's Code of Ethics (Art. viii, § 3) reads:—

"Neither societies for mutual benefit, for the insurance of lives or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege," namely, "valid claims for gratuitous services."

Those who wish to engage in such practice should have such section either erased or amended. Not one of several to whom I have mentioned the subject defends for a moment the practice, but agrees in deploring its prevalence. From this, I infer that a proper presentation of its enormity and wrong, will at once secure a promise from every honorable member of the profession that he will, if not resign forthwith, at least not renew his contracts when his present term expires. There is nothing "drastic" about that—he simply stays in the fold, or goes out, of his own action.

It is well enough known that most of these societies are wealthy and have funds invested. Such then should not receive our services as paupers or mendicants. Their membership and successful working are largely due to their furnishing medical attendance free. That is the main consideration for members to join.

Those physicians who serve them do so as an indirect means of advertising (at the expense of the profession at large). Hence the Committee on Ethics did well to put their objections to lodge practice and newspaper advertising and puffing on the same level, and condemn both in the same breath and in similar terms. If one kind of advertising is tabooed so should the other; for, of the two, accepting lodge work is the more insidiously sneaking and underhanded. The result will then be that only the most degraded sort of practitioners will be willing to accept such dirty and degrading work.

GALEN.

Pamphlets and Reprints.

Prospectus of the London Post-Graduate Course.

Proceedings of the Society for the Study of Inebriety.

Address on Hygiene. By Thomas J. Mays, M.D., of Philadelphia.

Spinal Surgery, a report of eight cases. By Robert Abbé, M.D, Prof. of Surgery, Post-Graduate School of New York.

Relation of Eye-strain to General Medicine. By George M. Gould, M.D., Ophthalmic Surgeon to the Philadelphia Hospital.

In the August number of *Wood's Medical and Surgical Monographs* are found: *Morbid Blushing, its Pathology and Treatment.* By Harry Campbell, M.D.; *Alcoholism in Women.* By Dr. Thorneuf, Paris; *The Different Methods of Lifting and Carrying the Sick and Injured.* By George H. Darwin, M.D.; *Treatment of Ingrowing Toe-nail.* By Joseph Amiard, M.D.; *Chronic Bronchitis and its Treatment.* By William Murrell, M.D.

Personal.

DR. J. D. THORBURN (Tor. '87) has recently returned to Toronto from Manchester, England.

PROF. OSLER, of Johns Hopkins Hospital, Baltimore, paid a flying visit to Toronto, Sept. 23rd.

PROF. HOWARD A. KELLEY and his assistant, Dr. Robb, from Baltimore, were in Toronto September 20th to 22nd.

DR. MCFARLANE, of Toronto, met with a severe accident while returning from Europe. When he was getting off the steamer at New York, September 16, he fell and received a compound dislocation of the leg about three inches above the ankle joint. He was taken to the Long Island College Hospital in Brooklyn, where he remains at present. No serious symptoms have appeared, and his condition is favorable in all respects.

Miscellaneous.

REFORM IN THE BURIAL OF THE DEAD.—We are glad to see that the subject of funeral reform is engaging the attention of the clergy. A society of clergymen in Topeka, Kansas, has passed resolutions opposing the custom, on the part of pall-bearers and friends, of uncovering the head at the commitment of the body to the grave. The local medical society has unanimously endorsed these resolutions. It would be well if all similar associations would pass resolutions to the same effect.—*Brooklyn Medical Journal.*