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MYOMA OF THE UTERUS.*

BY DR. F. R. ECCLES, LONDON, ONT.

The subject of myoma of the uterus has been engaging the mind of both the general practitioner and the specialist for the last decade as it never has in all the great years of the past. The restless spirit of man, in all departments of science, is pushing forward rapidly, and opening up paths never before trodden, and the department of medicine forms no exception. Some of these paths, during the last decade of the nineteenth century, will be well beaten, and some, no doubt, closed. At one time, and within the recollection of some here, the treatment of ovarian tumors by removal through an abdominal opening caused so much adverse criticism, and was attended by such untoward results, that what is now a well-beaten path might have been closed for half a century to come. Just at that time details of cases were noted and statistics kept in a more methodical manner than had ever been before; the result of which was a more rapid ripening of experience, largely beneficial to those just engaging in abdominal work. And so we find the differential diagnosis and treatment of myoma have been largely engaging the mind of the profession, since with the ripened experience of many operators the results of ovariectomy have been so encouraging, so successful.

Time will not allow me to enter largely into the diagnosis, and I have considerably curtailed what I had intended to say on this point in order to especially provoke discussion on the treatment. A time occasionally arises in those cases when symptoms which are common to many diseases must receive their due import, and the general practitioner, as well as the specialist, may here, right in connection with this subject, find it no small matter to determine to which of its many sources a particular sign or symptom is due. Hemorrhage is the most frequent symptom of myoma, but it is a symptom common to many other diseases, and a knowledge of *such* is absolutely necessary in order to determine the most likely cause of hemorrhage from the uterus in any given case. I do not think there is any branch of medicine to which these remarks are more applicable, any branch in which greater care is necessary in estimating the proper value of symptoms and history, than in the physiological and pathological processes which produce enlargement of the abdomen. It is to the general practitioner we look for the history and treatment of the great majority of cases of myoma of the uterus. They are first brought to the notice of the family physician by reason, perhaps, of a swelling having been discovered, or symptoms connected with the unfelt swelling—symptoms of pain or distress, or hemorrhage, either in connection with menstruation, or at other times; or he may discover the tumor accidentally, no symptoms being present. Great exercise of judg-

*A paper read before the Ontario Medical Association, June 4th, 1891.

ment is required not to create anxiety or needless alarm upon the first discovery of the swelling. The very knowledge of a tumor of any kind, to many women, is a source of the greatest worry; and as the great majority of cases may with care pass on to the climacteric without any very dangerous symptoms presenting themselves, these cases may remain under the care of the family physician with oftentimes greater benefit than if sent away to some specialist. To send a patient some distance away from home and friends for treatment frequently creates a condition of mental disquietude, which interferes with sleep, deranges the digestive organs, and impedes assimilation, so that I maintain that the judicious physician will, in the absence of any serious symptoms, manage these cases well, and conduct them to that period when one may expect a quiescence of symptoms, a cessation of growth, if not a retrograde movement. These remarks have reference entirely to the multinodular tumors, which are rarely single, and are intimately associated with menstruation, grow during that period, and decrease or disappear after the menopause, whether the menopause be natural or brought about by removal of the appendages.

The much rarer forms, the soft, are single and interstitial, grow at all ages, do not cease growing at the menopause, are not connected with or influenced by menstruation, and as a rule grow much more rapidly than the hard or multinodular. It is more than probable that all myomas of the multinodular kind are first intramural, and that they grow in the direction of least resistance, thereby following a natural law. If the resistance is equal, they remain intramural; if unequal, they become either subperitoneal or submucous.

Those who have had the opportunity of examining numbers of cases of myoma, both before and after operation, will have no difficulty in reconciling the variety of symptoms that present themselves in connection with this disease. Symptoms differ largely, whether the tumor be single or multiple, whether it grows from the posterior wall or anterior wall of the uterus.

In the nodular, the number of tumors, their arrangement and growth, produce an endless variety of configuration; and mixed up with this, a variety of displacement of tubes, ovaries,

and broad ligaments, and of the bladder itself. Recognizing this, one is prepared for a great variety of symptoms. Pressure upon the bladder, rectum, sacral nerves, the ureters, will produce symptoms referable to the organs thus encroached upon. Pressure on the ureters is more likely to occur in cancer than in myoma from infiltration around the ureters; in either case, it will lead to hydronephrosis. In the early stage, impaction in the pelvis, with or without retroversion of the uterus, may be produced. This must be recognized and freed, and is generally best accomplished just after the period, owing to the influence of menstruation. The tumor is largest just before, and smallest just after the period.

One case occurred to me in which there was a singular periodicity of pain, to me wholly unaccountable. The tumor was wedged in the pelvis, with no continuous but a characteristic intermittent pain three days on, and three days off. The pain was intense during three days, requiring full doses of morphia to relieve it, and the following three days she was quite free from pain; and the singularity was that the condition was not in any way influenced by menstruation.

Another case with exceptional symptoms was a patient from whom I removed, in December last, a myoma as large as an orange, growing from the posterior wall of the uterus. For several years she had been the subject of great nervousness, had frequent attacks of hysteria, and had been largely troubled with insomnia. At times she showed mental weakness, bordering on insanity. She had taken a variety of hypnotics before I saw her; chloral, bromides, opiates, sulphonal, antipyrin, antifebrin. The use of the latter remedy I discovered on Nov. 4th, 1890, owing to its toxic effect upon her. Her sister brought her to me ostensibly to consult me about the blue discoloration of her face (cyanosed condition) which had lately developed itself. Upon questioning her I found she had been taking a solution of antifebrin, *ad libitum*, to produce sleep. Formerly it had produced sleep, but latterly it had no hypnotic effect. Fearing some untoward accident on account of her mental condition, I now strongly urged what I had formerly frequently advised—an abdominal section. Four days later I made

the section and removed the myoma, removing at the same time the left ovary, very much atrophied, and the left Fallopian tube, largely dilated. No ovary could be found on the right side. This was a case of erroneous diagnosis. It was from the first thought to be a solid ovarian tumor dropping down behind the uterus. The sound was of no use here in diagnosis, for with it in the uterus the tumor did not appear to move with the uterus. Her extreme nervousness, coupled with the excessive tenderness of the tumor, a rare symptom in myoma, helped to lead me astray and confirm a diagnosis which was afterwards found to be incorrect. The change for the better in this case was immediate and continuous. Four, six, and eight hours of natural sleep, with improved appetite, digestion, and assimilation, followed almost immediately. Her moral and physical strength returned in a manner almost incredible. Symptoms here were entirely outside the normal, and not at all dependent upon the size of the tumor. Indeed, a very careful study of these cases in the early stage will determine a variety of symptoms which are not in common. Now and then cramping pains in the uterus, caused by a small myoma, are often put down to neuralgia, or hysteria, and cannot be diagnosed with certainty in the very early stage of the disease. But the most frequent and most important symptom, and the one which we will most frequently be consulted for the first time, is hemorrhage. This is because the disease occurs during the period of greatest activity of the sexual organs, between 25 and 45. It is more indicative of the submucous, or of the intramural. All varieties very frequently occur in the same case; but as a rule it is the submucous that is the most important to us clinically, the uterus contracting much in the same manner as it does in abortion, endeavoring thus to get rid of the foreign body. These painful contractions often end in separation of the myoma. First gradually assuming the pediculated form, then the pedicle breaking, the entire tumor is separated, and involution of the uterus takes place as after abortion. The increased vascularity of the uterus, as well as the largely increased surface from which the blood flows at the time of menstruation, accounts for the menorrhagia.

Frequent protracted and profuse menstruation should always engage our attention. The flow is a gradual increase, not a sudden flowing, as one sometimes finds in cancer. The interstitial that becomes subperitoneal rarely has symptoms aside from pressure or mechanical inconvenience. The difference of the location makes the history of the one variety differ from another; and if the tumors were single instead of generally multiple, the history alone would often lead us to a correct diagnosis of the variety. If in connection with the hemorrhage, and perhaps pain, we have enlargement of the uterus and deformity of its canal, we feel more certain of our diagnosis.

If the uterus has a firmer feel, we are still more certain; and if with the sound in the uterus we can make out one wall thicker than the other, that there is unevenness or change of form in the uterus, and that there is mobility, our diagnosis is almost certain. But when with the mobility the enlargement is smooth and even, the greatest difficulty may arise. Here we have a sort of equilateral triangle with sides; myoma, subinvolution, pregnancy, and hemorrhage and pain may be common to either side.

We cannot take up the sound until we have eliminated pregnancy; and in the unmarried the history must be taken *cum grano salis*. So here we are hampered in our investigations. Where much doubt exists, better wait.

I have had one painful experience, which taught me that even with the married abdominal enlargement ought to be considered apart from the history. A married lady, accompanied with her maid, consulted me for myoma; she mentioned a very excellent physician, whom I knew very well, and under whose care she had been for some time, and who advised her to see me. She had, spreading over a long period, the menorrhagia, the dysmenorrhœa, and various pressure symptoms, corresponding to a myoma filling the pelvis, and in addition so much tenderness that I could not properly examine her without an anæsthetic, which was administered to her at her hotel by a physician whom I asked to see her with me. Looking at her history of many months, coupled with the diagnosis of "fibroid" which she brought to me from a very careful and intelligent physician, threw me off guard. I examined rather

with a view to ascertaining in which wall the myoma was located. The bimanual examination did not help me in this respect, and I proceeded to pass the sound. At first there was some difficulty in passing it, and I began to think of a tortuous canal when suddenly the sound popped in to the depth of $4\frac{1}{2}$ inches.

The true condition of the case flashed across my mind at once; I said to the doctor, "That will do," stopped the chloroform, and put her to bed.

Fifty-six hours afterwards she had a miscarriage, which both she and her maid concealed from me, she positively refusing to be examined. On the fourth day dysentery with alarming symptoms set in, and, insisting upon examining her, she confessed she had the miscarriage, and that the maid threw everything down the water closet. She was extremely ill for a week; indeed it was a neck-and-neck race for life, and I spent three or four days between hope and despair. Truly she had the wisdom of the serpent, scarcely blended with the harmlessness of the dove.

The sound has therefore to be used with great hesitation. When there is doubt as between subinvolution, or retroversion of the uterus with subinvolution, the sound may settle the question. As to relying upon it to determine between a small solid tumor of the ovary and a subperitoneal myoma of the posterior wall, mistakes may be made. In the larger tumors occasional difficulty will be experienced in differentiating between soft myoma and pregnancy. This will be admitted, when men of the greatest experience, with the abdomen open, have made mistakes along this line. In two cases the operator, with one hand in the abdominal cavity and the other in the vagina, was so unable to determine that the condition was not one of pregnancy that he closed the abdomen. Time revealed the true nature of the cases, the abdomen was again opened, and in each case a hysterectomy was performed. Great caution in arriving at a diagnosis is necessary, and the careful physician will approach it by both the positive and negative methods.

The treatment will resolve itself into various methods, according to the age of the patient,

the urgency of the symptoms, her condition in life, and the character of the tumor, as well as on the peculiar bent of the mind of the physician under whose care the patient comes. I feel certain that in the records of treatment the latter remark will bear emphasizing. Indeed, upon the great question of the treatment of myoma, the medical mind is still unsettled. Dr. Keith, by a brilliancy of results, had far outstripped his compeers, and had almost established hysterectomy on a firm basis as the treatment for myoma in bad cases, when a treatment with much less strain on the nervous system, and requiring much less courage on the part of the operator, was embraced and championed by the great Scotch surgeon. The voluntary and conscientious departure of Dr. Keith produced some commotion in the medical world, and soon provoked discussion in which, I am sorry to say, personal feeling and professional animosity were too apparent.

As I said, hemorrhage is a prominent symptom, and the one for which we will be the most frequently consulted, and the question now and here arises, Is there any medical agent of any avail in checking hemorrhage and retarding the growth of the myoma? I know of but one; that is, ergot, which produces more constant results when used hypodermically than by any other mode of administration. The preparation is important; it should be fresh, and injected deeply into the tissues. Great care is necessary in keeping the needle and syringe aseptic, and the syringe should not be used for any other purpose. The only drawback is the occasional formation of an abscess, despite the greatest care. But I am satisfied, if the preparation is right and perfect cleanliness maintained, that abscess will be very infrequent. I have continued this treatment for months, and I have seen the hemorrhage controlled and tumors largely diminished under the influence of the drug administered in this manner. It acts by diminishing blood supply as well as producing contraction of the tumor itself, and this retards growth.

Perhaps it is more uniform in this respect than in its more frequent use in accouchement cases. Curetting the uterus when the endometrium is diseased, rest during the whole period of menstruation, frequent hot douches,

and the continued use of ergot for months and months, will accomplish more than any other line of medical treatment that I know of. It is important to remember that in not a few cases of myoma we find the endometrium more or less covered with fungoid vegetations. Here dilating the cervix and thoroughly curetting the uterus is productive of the greatest benefit, and often checks hemorrhage for months, if not entirely. The skeptical can raise objections to cases of supposed cure according to this treatment, or any line of medical treatment, and I admit there is abundant room for fallacy. Some cases disappear spontaneously, some cases cease to grow sooner than we expect, and atrophy after the menopause. Admitting all this, and yet a number of cases appear to be benefited by the above treatment.

Sometimes under the influence of this treatment, or otherwise, the tumor becomes submucous, and the uterus, treating it as a foreign body, puts forth efforts to force it out of its cavity. The continued contractions may in process of time render it sessile or pediculated.

Dilatation of the cervix and appearance of the myoma at the external os or in the vagina take place by degrees, when the lowest portion, owing to constriction, or other causes, sloughs, a foul-smelling discharge is noticed, and a not careful examination causes it to be frequently mistaken for cancer.

In more than one case has this come to my notice lately; frequent hemorrhages and fetid discharges are occurrences in the history of cancer, but with care a mistake of this kind will not occur. The myoma is removed with the ecraseur. If too large to be removed through the vagina readily, it can be pared away, and the wire loop then slipped over it and the remainder removed. But in a greater number of cases the tumors grow, the menorrhagia increases, the discomfort is more and more felt, and the general condition is daily becoming worse. What then is to be done? Formerly I divided or dilated the cervix, and in some cases got prompt relief from pain, as well as from hemorrhage. The rationale I am unable to explain, but the result is beyond all possibility of question. This little operation is not without danger, and should always be done,

as all operations about the genital canal should, under strict antiseptic precautions.

For some time past the cases that I formerly would have treated by division of the cervix and administration of ergot, I now treat with electricity. In a very few exceptional cases, I have given ergot while using the current. This was on account of the difficulty of controlling the menorrhagia—cases in which I could not always depend upon the positive current checking the hemorrhage, from not being able to use a sufficiently large dose, or other unknown causes. Indeed in a very few cases at times the hemorrhage was increased after the use of the current. Nearly all cases for the last two or three years, where hemorrhage has been a prominent symptom, have been treated in this manner. Electricity, properly dosed and properly administered, is a potent remedy in gynecological practice. To say that I have been satisfied with it in the treatment of myoma would be aside from the truth. I am rather compelled to say that I have been disappointed with it, but that has partly arisen from too great expectations; I imbibed too much enthusiasm in the enthusiastic praise of the remedy; I soon found that under the current the myomas did not disappear like dew before the sun.

Just now attempts are being made to push the pendulum to the other extreme; bitter and most severe attacks have been made upon the treatment and those who use it, and an unwarranted condemnation of it, with a too hasty trial, I fear, has been made in some quarters. In calcareous and cystic degeneration it will be found of no benefit whatever; indeed, I believe the cystic part grows more rapidly under the influence of the current. The same, I believe, occurs where a myoma and an ovarian cyst occur in the same patient.

I have witnessed a much more rapid growth of a cystoma when the large myoma masking the cyst was being treated by electricity. I have learned in this line of treatment, which some are pleased to call the latest fad in gynecology, as well as in many other lines, how difficult it is to keep one's mind free from bias, and I think I have observed the same in a few others; but I have endeavored, during my short experience, to test as best I could its efficacy in the treatment of myoma. I have always,

when I could, introduced the intra-uterine electrode through a bivalve speculum, first washing the neck of the uterus with absorbent wool dipped in antiseptic solution. In some cases, from the position of the os uteri, this was impossible; then the vagina was simply washed out with the solution, and the electrode introduced. For negative currents any metal will do, and I have frequently insulated the sound with rubber tubing, and used it; but for the positive current I have only used platinum electrodes. I have always commenced with weak currents, 20 to 25, and increased according to the tolerance and urgency of the case, and 275 milliamperes is the strongest current I have at any time used.

On account of the cleanliness and ease of application, I have generally used Dr. Martin's abdominal electrode, and the applications have been two or three times a week. As a rule, no perceptible diminution takes place for some two or three months; and were it not that the hemorrhage is controlled in the bleeding cases, the patient and physician would feel much discouraged.

One case impressed me very much with the utility of the current. It was a case in which the tumor was tightly wedged in the pelvis, with cervix forward and behind the pubes. I tried in every possible manner to extricate it; with two fingers in the rectum and volsella grasping the cervix, and patient in knee-elbow position, I was unable to get the tumor above the promontory of the sacrum. The bladder and rectal symptoms were distressing, and the catheter had been used for some time before I saw her. By pulling on the cervix with the volsella, I was enabled to worm a pliable electrode into the uterus; and after some 20 or 25 sances, the uterus passed up out of the pelvis with the greatest ease. I am satisfied that there was diminution in bulk quite one-third. In one case I have had an almost total absorption of the tumor. To sum up my limited experience in the treatment of myoma by the current: We have in electricity a remedy powerful to control hemorrhage and relieve pain, a remedy that in nearly all cases affects the general health for the better; the patients feel better, the digestion and assimilation are improved, and there is in general greater buoy-

ancy of spirits; a remedy that in a minority of cases produces an evident diminution of the tumor, and in a still smaller minority produces an entire disappearance of the myoma.

The drawbacks to its general use are, the expense of the apparatus; great consumption of time at each treatment; the necessity in many cases of a continuation of treatment for months, during which the patients often become discouraged on account of the slowness of the treatment; and when one has not a private hospital, the necessity of patients having rooms near his office.

Removal of the uterine appendages in suitable cases has been gaining ground during the past few years. One cannot close his eyes to the success of the operation *per se*. Whether the induced climacteric will permanently arrest or diminish the growth, sufficient time has not yet elapsed in a sufficiently large number of cases to speak absolutely on this point.

My own opinion is that imitation of nature may be nearly as effectual in arresting myomatous growth as the natural menopause itself. A few patients have become insane after the operation; that may be an accident or coincidence, and will not largely enter into the merits or demerits of the operation.

The mortality has now been brought so low, and the operation in early cases before the myoma becomes large so easy, that even without large experience in abdominal surgery one would be justified in doing the operation in cases of bleeding myomas where neither the medical nor electric treatment has been of avail, and in those cases would I especially emphasize the necessity for operation where years will elapse before the climacteric will be reached.

Then in cases of non-bleeding fibroids, or where the bleeding has been arrested by treatment and yet the myoma is enlarging, the operation is justifiable, with the hope that the induced menopause may at once arrest the growth. For the very small remnant of cases—cases where neither medicine, electricity, nor oophorectomy is of any avail, or where from displacement of the ovaries, or enlargement of the tumor, the ovaries cannot be removed, nothing remains but the major operation of hysterectomy. Would that it always remained

for cases baffled by other treatment—uninfluenced by every other resource of our art. Ovariectomy fought its way through many long years, encouraged and discouraged, halting now and then amidst showers of reproach; but it stands out to-day one of the most successful, as well as one of the most justifiable, operations in the surgical realm. It is not to be wondered at, therefore, that the success attending ovariectomy encouraged operators to deal with the myomatous uterus in a similar manner. But the cases are different; and were the mortality in hysterectomy as low as in ovariectomy, it would even then not be as justifiable an operation as the latter. In this case we have a disease whose evident tendency is to destroy life, and that in a very few years; whereas in the other we have a disease whose evident tendency is not to destroy life, and not to grow after the climacteric.

We would not forget, however, that in a small percentage of cases it does destroy life, directly or indirectly, and in a somewhat larger percentage it does entail long years of discomfort and suffering, and more or less invalidism, until the climacteric, often protracted, comes. On the one hand, we have a disease attended by a frightful mortality; on the other hand, a disease attended with a very small mortality. On the one hand, an operation attended by a very small mortality; on the other hand, an operation attended with a large mortality; for abdominal hysterectomy is a much more dangerous operation than ovariectomy, and requires greater skill, presence of mind, and balance of judgment. Indeed, most serious consideration and a high sense of responsibility becomes one who proposes a hysterectomy. In a large number of cases the operator has to map out his path after the abdomen is opened, for he cannot determine beforehand what line of procedure he will take, and just on this account does experience reap its reward; and in addition to this, it is sometimes very difficult to determine when to operate. An operator has no right, in discussing the possibilities of an operation, to quote the lowest statistics that have been reached by the best operator unless he be that operator himself. To tell a patient who places the responsibility of her life in your hands that the chances are 6 out of 7, or 7 out of 8, because

such results have been achieved by the very best and largest experienced operators, is hardly honest to the patient. It is in extreme cases, where the tumors are very large and the patient has a number of years to run before she reaches the menopause, and where there is no other course open, that we should recommend abdominal hysterectomy, and these cases are extremely rare; and with the various other methods, less dangerous, which are now being applied in the earlier history of these tumors, let us hope that the cases will be still more rare. I think one is safe in venturing the statement that, in the very near future, very large myomatous tumors will be as rare as very large ovarian tumors. Accidents may call for the operation where the operation is not intended; this happened to me where a large sinus in a myoma was thought to be a cyst and was opened; the alarming hemorrhage could not safely be controlled, and the tumor and part of the uterus was removed. This was some years ago; and after double transfixion and tying, I dropped the stump back into the peritoneal cavity. There was some suppuration of the stump, but the drainage tube saved her by keeping the septic influence local. Ten months afterwards with some little force I removed the ligatures from the external os. They had been the cause of more or less discharge, which ceased on their removal. My experience and knowledge therefore lead me to discountenance hysterectomy in the treatment of myomata; that there are safer pathways which, if traversed early, will lead to good results and an exceedingly low mortality—which cannot, of course, promise as complete a cure as hysterectomy, but which promise something very much better—a saving of life.

ABSTRACT OF THE ADDRESS IN SURGERY,

Delivered at the Meeting of the British Medical Association,
1891,

BY JOHN CHIENE, M.D., F.R.C.S. ED.,
F.R.S.,

Professor of Surgery at the University of Edinburgh; and
Surgeon to the Royal Infirmary, Edinburgh.

MR. PRESIDENT AND GENTLEMEN,—“There are duties difficult of fulfilment pertaining to every position in life, and there are duties attached to public professional life from which no man can assume to himself the right to shrink, with what-

ever diffidence and incapacity they may be undertaken." These are the opening words in one of my favorite books, and they express my feelings so well to-day that I do not hesitate to adopt them. Some years ago a friend of mine was sitting in the Surgical Section at a British Medical Association meeting. He overheard a conversation near him. "Who is that sitting at the table?" said one, pointing to an office-bearer. The answer was, "I do not know him, but he must be a wise man—he has never opened his mouth since I entered the room." The person under discussion was then Secretary of the Surgical Section; he now occupies a more important position, and his first thought this afternoon in addressing you is that he is throwing away his best chance of being considered a wise man. The silent people in this world, as a rule, have the best of it, but silence is not permissible to me to-day.

My hero for to-day, whom I never saw, but whose one great work has been to me a classic, taught me to value a great principle, and I cannot but think that those present who knew him personally, who worked with him and were taught by him, will be the first to acknowledge that in taking him, and the great idea which he loved to inculcate, as my mainstay to-day, I am leaning on a strong staff, and that it will be entirely my own fault if I do not make the subject an interesting one. To those present who knew him not—there are not many present who do not know his work—it is an absolute pleasure to me to be the imperfect medium of an introduction. My hero is John Hilton, and my principle is *rest as a therapeutic agent in the cure of surgical ailments*.

Bacon says there are books to skim over, books to read parts of, books to absorb; Hilton's book on *Rest and Pain* is one to absorb. Since Hilton's time—born in Essex in 1804, died in 1878—many changes have taken place in the practice of surgery. I ask, and wish to try and answer the question, What bearing has Hilton's main idea—good for all time—on our present work as surgeons? While I gladly grant that in this audience there are those who could, from more extensive knowledge, bring Hilton more vividly before you, yet I will yield to no one in my intense admiration for the man and for the principle.

I am not going to attempt to define rest, or its opposite—unrest. There is always some molecular movement going on during life, a part can never be in a state of absolute rest. The term must always be a relative one. It has been divided into mechanical and physiological, but this division is a purely arbitrary one. It has, however, a mental and a bodily aspect—a psychical and a physical side; and without further preface, I will take up first the mental, and afterwards the bodily, aspects of rest and unrest.

We all know, it is not work, but worry—mental unrest—which kills, so a person will bear much physical discomfort in order that he may be relieved of the mental discomfort of his condition. I take into consideration in my practice and in my operations the effect that my decision in recommending any special treatment will have on the mind of my patient. In operations for cancer we all know how frequently they are unsatisfactory, but I think we hardly estimate the great mental depression which often follows on our refusal to

attempt to give relief, more especially after the recurrence of the disease—after the primary operation has taken place. An attempt, even if unsuccessful, to remove a tumor will often give the patient a feeling of mental rest in the thought that no stone has been left unturned in the endeavor to give relief. I desire, as far as I can, to give my patient mental rest, and for this reason I am often impelled to make the endeavor by operative means to give that relief which, looked on simply from the physical side, it may be impossible to underestimate; but, looked at from the psychical side, it may be impossible to overestimate. For example, there is a class of cases which I have sometimes termed the "phobias"—syphilophobia, cancerphobia—in which the whole disease is psychic, and I know no condition in which I have more pleasure in giving relief, because the condition of these patients is a most unhappy one. There is one aspect of the mental side of disease which has, in my opinion, not received the attention which it deserves. When a patient is confined to his bed, away from his work, he is often suffering as much from the worry of mental inactivity as from the physical disease for which he is under treatment. I feel sure that the prescription "don't worry" might with advantage be burnt, and that "do some work" should take its place. I have seen some patients suffering from aneurysm who have shown decided improvement by encouraging them to do some light mental work.

This is an age of diagnostic incisions on the part of surgeons, and faith on the part of patients that after the incision has been made, and the part thoroughly examined, the surgeon will have more light, and be best able to judge as to what should be done.

In diagnostic incisions I believe we have a valuable aid in avoiding psychical unrest. These diagnostic incisions are the direct outcome of the minimized danger of such incisions. A new diagnostic power has been placed in our hands. The first step in the operation is the diagnosis, and the surgeon has no hesitation in taking this step. He requires from his patient a free hand; he takes less on faith and more on sight. He avoids the necessity and uncertainty of guessing, which, perhaps, gave to the surgery of the past much of that something which made great diagnostic surgeons; but we must remember that this diagnostic power was the direct outcome of an experience largely founded on mistaken diagnosis. The present method trains the ready surgeon, and is in my opinion the method which best attains the object desired, namely, that the best is done for the patient.

I need not dwell on anaesthesia as a cause of rest in our patients, except to say that I still adhere to the views I expressed in a paper on chloroform, read at the Cardiff meeting in 1885. I still hold that chloroform is the best anaesthetic; and I cannot help, as a pupil of Syme, feeling pride that the decision of the Hyderabad Commission, presided over by Dr. Lander Brunton, so fully bears out the views held by that far-seeing man. Cocaine, as a local anaesthetic is, in my opinion, of great value in adults. I have never seen any of the evil results, local or general, which have been described. We must take care to use a pure solution, and see that we do not inject it directly into a vein. These are the precautions which I have taken; and I use it

either as a solution of salicylate of cocaine, or kept in pellets, and dissolved when required in camphor water or distilled water. I never inject more than half a grain. I allow four minutes to elapse after injection before performing the operation. To prevent urethral fever—a purely nervous lesion—before passing an instrument I have used it in the form of a cocaine bougie. It is right to say that the use of local anesthetics, such as cocaine, ether, or chloride of ethyl, may be overdone. The work of the surgeon may require to be done in too hurried a manner, not altogether satisfactory either to the patient or to the surgeon. Mental unrest, arising from a feeling of work imperfectly done, worries the surgeon; and in any operation requiring time chloroform is to be preferred to the local anæsthetic.

Pain given to a patient, whether in the dressing of a wound or in the examination necessary to make a diagnosis, is a most fertile cause of unrest. Confidence is lost between patient and surgeon; this is more especially true in children. When I hurt a patient I always feel I am doing or have done wrong. Healthy wounds are not painful; the healing of a wound is a physiological process closely allied to—in fact, it is—growth. Inflammation in our wounds can be avoided, and, if avoided, then pain as a cause of unrest is unknown. Pain is to be avoided by every means in our power. Any movement of the patient is apt to cause pain, and every endeavor should be made, in the examination of the patient, to avoid pain. Pain given to a patient, in making a diagnosis or in doing a dressing, is a fertile cause of unrest, and should be avoided, since it tends to destroy the confidence existing between patient and surgeon. This is especially true in children. In this connection the many-tailed bandage is eulogized as a means by which movement may be avoided in changing dressings.

One of the most frequent causes of local unrest in wounds and the free serous oozing which accompanies it is the use of unnecessarily strong antiseptics. We cannot avoid them altogether. We must use them in a thorough manner for the purification of our hands, of the skin of our patient, and for our instruments if we have not a sterilizing apparatus; but as regards the wounds itself, given an antiseptic wound to begin with, the less of the antiseptic the better; it is an irritant. A good many years ago a smart writer in a medical journal said, "Lister's arguments are getting stronger, his solutions are getting weaker." If he had said, "his arguments are getting stronger because his solutions are getting weaker," he would have been nearer the truth. Asepticism is taking the place of antisepticism. The extent to which this can be carried out will depend on the security we feel when we operate on unbroken skin that we have not introduced any causes of fermentation. If we have not this security, we must wash out our wound, after stitching, with an antiseptic, but let it be followed by an aseptic fluid in order to remove the antiseptic—the irritant—or, at any rate, see that no antiseptic is left in the wound.

Another aspect of Hiltonism is the use of absorbable drains, so that dressing of the wound is not required in order to remove the drain. Pressure and careful apposition of the edges and surfaces, combined with the absence of any irritating

antiseptic, have, to a great extent, done away with drainage of any sort; but here I think I have over-shot the mark, because if any bleeding occurs, and if the pressure is not accurate, accumulation of blood takes place, and delayed healing is the result. This has lately been one of my main troubles in wounds, and I recall three cases of excision of the mamma within the year in which this has occurred and delayed union. I think the safer plan is drainage for twenty-four hours during the time when reactionary hemorrhage is likely to happen. If India-rubber tubing is used it can be arranged so that it can be removed without disturbance or exposure of the wound; cause the tube to project beyond the wound surface, then the blood and serous discharge pass into the substance of the dressing, and have no tendency to pass along the skin surface to the edge of the dressing. Free evaporation through the dressing is all-important. Dr. Werne Clarke has recently brought under my notice a corrosive dressing in which the outer layer is impermeable to liquids, although it allows of free evaporation. This dressing is made by Robinson & Co., Chesterfield, and, from the trial which I have made of it, I think it will take a place in surgical practice. Drainage and rest are best attained in psoas abscess by a posterior opening in the angle between the outer border of the erector spinæ and the crest of the ilium, and in retro-pharyngeal abscess by an opening posterior to the sterno-mastoid muscle.

Use leaden splints to steady limbs after amputation and excision. Shape the splint so that it can be unfolded without moving the limb. Anchor the arm by the side with a leaden splint after excision of the mamma. Apply your pressure firmly, but always leave a distal portion of the limb exposed, so that, if it swells, then the pressure is overdone and the bandage must be loosened. We know pressure is properly applied to any part if it fulfils two conditions, painlessness and non-interference with the blood current through the part.

Horsehair stitches are valuable, combining rigidity with elasticity—rigidity acting as a splint steadying the edges, elasticity enabling them when cut to be removed without pain. After cutting a stitch, lay hold of the knot and pull towards the side on which the loop has been cut; in this way all strain on the edges of the wound is avoided.

A plaster applied over a boil in its early stages acts as a splint, steadies the part, and relieves pain. The boil is frequently aborted by this simple means.

These, gentlemen, are simple things, and I feel as I write that I owe an apology for their simplicity. They are, however, all illustrations of the effect which Hilton's work has had on my practice, and I hope they will be pardoned.

The value of extension in the treatment of fractures of the lower extremity is universally acknowledged, and it is perhaps not sufficiently used in fractures of the upper extremity and after excision of the knee and elbow. Excision is also of undoubted value in fractures, diseases and injuries of the spine, in sacro-iliac disease, and in fractures of the pelvis. It is most valuable in affections of the mobile portions of the spine—the cervical and lumbar regions. In the cervical region the head may be fixed by a hollowed sand pillow, a poroplastic splint, or with Fleming's rubber collar.

Treves has also demonstrated the value of rest in the treatment of enlarged cervical glands.

In all cases in which complete rest of the trunk is called for, use a thick and firm mattress made in three pieces, the central portion of which can be withdrawn for the performance of the acts of defæcation in both sexes, and the act of urination in the female. The prevention of bedsores by the facility with which the sacrum and buttocks can be examined, and the dressing of these sores, when they do occur, is greatly facilitated by the triple mattress. In the diagnosis of injuries in the region of the hip, the use of Nélaton's line has been given up in my practice, because in order to reach the ischial tuberosity necessary for estimating the line the patient has to be moved. Its place is taken by noting the want of parallelism between two tapes, one passing through the anterior superior spinous processes, and the other through the tips of the great trochanters of the femur.

On the arrest of hemorrhage we have a valuable paper by Dr. Milne Murray in the *Edinburgh Medical Journal* of August and September, 1886, on the explanation of the action of hot water, which well illustrates rest. He shows that the general shock and the local reaction are greatly lessened after using hot water, as compared with the former method by means of cold. In epistaxis prevent the air passing through the nasal cavity by tightly grasping the nose, and the epistaxis will frequently cease, the part being kept at rest.

In cranial surgery, in the curved incision, as suggested by Mr. Victor Horsley, we have a means of restoring a flap to cover and give support to the denuded brain tissue or dura mater. In intracranial hemorrhage, intra- and extradural, we now feel justified in cutting down and arresting the hemorrhage by ligature, or by the hot douche; and from one case in which I operated on a person, comatose, with Cheyne-Stokes respiration, and a pulse of forty to the minute and on the point of death, I feel justified in recommending that, in apoplexy, an opening into the cranial and dural box is a justifiable surgical procedure, giving rest by relieving tension. This patient was shown by Dr. Smart at the Medico-Chirurgical Society of Edinburgh in June of this year.

In spasmodic wryneck we have the patient in constant unrest. But relief is given by excision of a portion of the spinal accessory nerve. In March, 1881, I showed a case at the Medico-Chirurgical Society of Edinburgh. From the result in that patient, and from similar cases which I have seen since 1881, I think the operation well worthy of more extended trial.

In rectal surgery gradual dilatation of the sphincter ani before operations gives rest after the operation, as it is followed by a temporary paresis. In colotomy the inguinal region is preferable to the lumbar, because mental worry is avoided by making an artificial anus in a situation which the patient himself has under command. In lumbar colotomy the *cul de sac* between the rectal stricture and the opening in the colon fills with feces and causes unrest. In inguinal colotomy, if the opening is intended to be a permanent one, I bring the whole lumen of the sigmoid flexure out as a loop through the wound in the wall, and fixed there with long pins passed through the abdominal wall

and mesocolon, and again through the abdominal wall, bringing the parietal peritoneum in contact with the visceral peritoneum. Stitches are a source of unrest; simple apposition is all that is necessary to obtain firm union.

In the ligature of internal piles the division of the mucous membrane at the anus with scissors before transfexion and ligature and tying the ligature tightly so as completely to strangulate the pile are both means which diminish pain after the operation. The pile mass dies without any inflammation; it dries of dry, painless gangrene. If this had been more frequently attended to, we should have heard less of other methods of treating internal piles. While I say this I desire most emphatically to express my complete accordance with Whitehead's view, that in cases in which the whole circumference of the gut is affected, excision is the most thorough and satisfactory method of treatment.

In disease of the bladder the systole and diastole of the organ may be checked by tying in a gum elastic catheter with the eyelet just within the viscus. To the other end of the catheter is attached a rubber tube which leads to a vessel containing water at the side of the bed, and in this way a siphon action is secured and the bladder is kept empty.

In tracheotomy, Hilton points out the value of rest to the inflamed larynx. One of the main objects of the surgeon is to prevent any blood getting into the trachea, and thence to the lungs, where it is the most fertile source of unrest, setting up pneumonia, the common cause of death after tracheotomy, when the death is not due to the disease for which the operation is performed.

In the treatment of cut throat, if we perform tracheotomy at once, and accurately unite the wounded surfaces, we attain more rapid healing, because the wound is not used as a funnel through which the air is admitted to the lungs. Movement of the parts is reduced to a minimum; the part, in fact, is kept in a state of rest encouraging and facilitating healing.

In the application of a bandage to varicose veins, let us see that it is applied before the patient gets out of bed, and taken off after he is in bed; so also in the application of a truss in hernia the same rule must be constantly followed. Allow the veins to fill, or the hernia to come down once in twelve hours, and the bandage or truss ceases to act as a curative, and only acts as a palliative agent.

Before I conclude I would wish it to be understood that there is another side to this picture, or perhaps it may be the same picture looked at from a different standpoint. It is that much harm may be done by too excessive attention to rest. Evil may result from too prolonged rest. Mechanical rest may, in one sense, be antagonistic to physiological rest. Mechanical rest, in many cases, must be interfered with in order to attain physiological rest. An example will best show my meaning. Immediately after an injury the effusions into the tissues may, by their presence, interfere with the normal blood current through the part. At a later date these effusions are replaced by organized material which will also act in the same way. The nerve equilibrium will also be altered. The part will then be, from the vascular and ner-

vous side, in a state of physiological unrest, and this unrest will be intensified by prolonged mechanical rest, because, unless there is a normal blood current, the effusions and fibrous material will not be removed. It is, therefore, necessary that, while we maintain mechanical rest after a part is injured, we should at the same time adopt some means to remove these products. It is here that massage is so valuable; lightly applied it has a marked soothing influence on the nerve disturbance; more strongly, though still gently, applied, it will get rid of the effusions by causing a temporary congestion and free flow of blood through the part; still more strongly applied, it breaks down fibrous adhesions and gets rid of the pain felt in certain movements of the limb. While the massage interferes with the mechanical rest, it acts directly in relieving the physiological unrest. Experience alone will tell how far we can go with massage in order to attain the one object—the physiological rest—while at the same time we avoid doing harm by its over-use by interfering with the mechanical rest. In acute sprains and strains it may be begun at once, gently night and morning, using elastic pressure with wadding and a flannel bandage in the intervals of massage. In subacute cases it may be used more freely, wearing an elastic bandage in the intervals, along with limited use of the injured limb. In chronic cases, which are non-tuberculous, adhesions may be freely broken down, often giving immediate relief after months of partial impairment of usefulness.

I am also strongly of opinion that in fractures near joints, as in Colles' and Potts' fracture, massage may with advantage be begun within a week, with the result that while the repair of the broken bone is in no way interfered with (I rather think it is aided), the limb is a useful one at a much earlier period than is the case if, as in the orthodox treatment, the limb is kept absolutely quiet for three or four weeks. If we think only of the broken bone and forget the injury to the surrounding soft parts, the result is a stiff and useless limb, which will for a long time be a source of discomfort and helplessness to the individual. It is a question exercising my mind whether we should not apply gentle massage in all fractures, as a matter of routine practice, so long as we can do so without displacing or causing movements between the broken fragments of the bone. The use of extension during the massage applied to the limb beyond renders this method much more feasible than it formerly was, when we depended entirely on splints applied at the seat of fracture commanding the joints above and below. It is interesting to note in this connection that no fractures heal more kindly and quickly than broken ribs, in which it may truly be said that during the whole process of cure the act of breathing is keeping up a constant gentle movement, a nature's massage, which in no way interferes with the union of the broken bone.

In breaking down adhesions in old standing cases of fracture, sprain, or strain, one must act in a decided manner. Their presence is associated with limited movement, pain on movement, or pain on pressure, and the use of firmly applied rotatory massage, or the sudden stretching of the tissues which are matted together, often gives immediate and lasting relief.

In the case of nerve stretching in sciatica, the

cases which are benefited are, in my opinion, those which may be called trade sciaticas, due to some special position adopted in the special trade pressing on and irritating the sciatic nerve. You freely stretch the nerve, but do not interfere in any way with the sensory and motor functions, and the pain is relieved by breaking down the fibrous adhesions in the nerve sheath and among the nerve fibrils.

New lamps may have been expected of me today; if so, my hearers have been disappointed. "Let us make a stand on the ancient ways, and then look about us and discover what is the right and straight way, and so walk in it." Bacon was fond of quoting this passage, and it has been my motto. I have taken my stand on an ancient way; I have tried to polish and refill an old lamp.

AN ADDRESS

DELIVERED AT THE OPENING OF

THE SECTION OF OBSTETRICS

At the Annual Meeting of the British Medical Association, held in Bournemouth, July, 1891,

By WILLIAM J. SMYLY, M.D.,

Master of the Rotunda Hospital, Dublin.

GENTLEMEN,—My first pleasing duty is to thank the Council for the honor they have conferred upon me in appointing me President of this Section. At the same time, I do not flatter myself that this selection has been made because of any peculiar fitness on my part to fill such an important post, but rather as a token of esteem for that great institution over which I have the good fortune to preside. The reputation of the Rotunda Hospital is due, I believe, not so much to its being the oldest and largest institution of its kind in these countries, but to the number of pupils which it attracts and sends forth annually to all parts of the world. The institution consists of four departments, and the numbers annually treated in each are about as follows:

Delivered in the Lying-in Hospital	1,200
Attended in their own homes	1,800
Admitted to Gynaecological Hospital	450
Out-patient Department	8,000

A good teaching institution must, in my opinion, comprise these four departments. Midwifery and Gynaecology must go together; they are sciences which God has joined together and should never be put asunder. In this I am quite aware that I differ from some who have occupied this chair before me, who have expressed a hope that this Section may soon split into two—a wish which I most earnestly hope may never be realized.

Some months ago a woman came to the Rotunda Hospital with a kyphotic pelvis, the tuberosities of the ischia being separated by an interval of only two inches; her former labor had been terminated by craniotomy, and she was very anxious to have a living child. I did not think that induction of premature labor would give any prospect of a living child, so I advised waiting until term and then Caesarean section. To this she readily assented, so six weeks ago I performed the operation with a favorable result to mother and child. An exact diagnosis and careful measurement of the pelvis are essential preliminaries to scientific treat-

ment, and these are the duty of the obstetrician and not of the pure gynæcologist. For accurate pelvimetry I most strongly commend to you Skutsch's pelvimeter, which I now show, and which is the only instrument by means of which accurate measurements can be obtained.

A few weeks ago my assistant, Dr. Bagot, was called to a patient in the extern maternity. In a tenement house not far from the hospital he found a poor woman almost collapsed from severe accidental hæmorrhage, which had been at first concealed. The pulse was 148, very small and compressible; her lips were quite blanched, and her pupils dilated. There was jactitation and sighing respiration. The uterus was larger than the term of pregnancy, though the membranes had been ruptured before his arrival, in order to check the bleeding. The child presented in the first position, vertex, no foetal heart could be heard. The os, which was rigid and undilatable, admitted one finger only. On pushing up the head, the blood flowed freely out of the uterus. Labor had not set in, though she had all night suffered from severe distension and pains in the uterus. Believing that owing to her collapsed state it would be impossible to deliver her alive by perforation followed either by version or extraction with the cranioclast, he at once performed Porro's operation, treating the pedicle extraperitoneally by means of a *serre noué* and pedicle pins made out of two Peaslee's perineum needles, as he had no time to procure proper pins. The placenta was found at the operation to be completely detached, and the uterus was full of clots; the child of course was dead. She was removed to the Rotunda Hospital on the fourth day after the operation, and has made an excellent recovery, though still very anæmic.

The arbitrary division between midwifery and gynæcology is peculiar to this country, and is due to their separation in special hospitals, so that the gynæcologist has come to despise midwifery, and the obstetric physician is often a poor operator.

I would not deny to any man the right to limit his practice as he may see fit; he may treat piles only, or fistula, or cancer, or may confine his attention to abdominal surgery; but what I do maintain is that, in teaching, gynæcology must not be separated from midwifery, and their isolation places such difficulties in the way of students that practical midwifery is not efficiently taught, and the study of gynæcology is more or less optional.

Let me now give you an account of a septic outbreak which we experienced in the Rotunda Hospital during the spring and summer of last year, and of the measures taken to eradicate the disease. When I was appointed to the hospital on November 1st, 1889, there had not been one death from any septic cause for 18 months, that is, out of 2000 deliveries. These results were so brilliant that I thought it inadvisable to make any changes in the methods employed for the prevention of septic infection. I will briefly state what the routine then was. A patient was permitted to be examined abdominally by any number of students, but vaginally by three only and one pupil midwife. Previous to examination the external genitals were carefully washed with soap and water, irrigated with plain water, and finally bathed with corrosive sublimate solution, 1 in 500. The examiner's hands

were thoroughly cleansed with soap and water and a good nailbrush, the soap removed by irrigation with carbolic lotion, and the hands then washed in the sublimate solution. Prophylactic douching was only employed in cases of purulent or septic discharges and where operation was required. Douching after delivery was employed only when specially indicated. For example: in hæmorrhage, after the introduction of the hand or instruments, after the birth of a putrid foetus, for putrid or purulent discharge, and in fever. For some months prior to my appointment plain water alone was used for uterine douching, and, though personally I was in favor of the use of antiseptics in such cases, yet with such good results I felt that the experiment might be continued. This favorable state of affairs continued up to January, 1890, when a patient, sent up from the country for induction of premature labor, died of acute septicæmia. It was exceedingly difficult in this case to excite uterine action, the catheter had to be inserted several times, and on one occasion caused some hæmorrhage, having evidently caused a partial separation of the placenta. Hot douches, Barnes' bags, and rupture of the membranes had to be resorted to in order to procure delivery. Acute septicæmia set in the next day with a measly rash, and she died within a week. The health of the other patients during this month was excellent; in one other case only did the temperature reach 101°F.

In February there were 73 deliveries, and in 7 the temperature reached 101°. In March there were 108 deliveries, with 13 morbid cases in which the temperature reached 101°. This great increase in the morbidity alarmed me, and I exhorted the pupils to increased care in disinfection, but still the morbidity increased, twelve cases of high temperature—101° and over—occurring in the first fortnight. I therefore stopped all vaginal examinations, and all trouble ceased. It may seem strange to those who place reliance for information upon vaginal exploration only to hear that in a great institution where deliveries average 100 a month we would give up this method of examination; but by abdominal palpation all necessary information can be obtained, excepting only as regard prolapse of the funis and the condition of the os uteri; but the frequent examination of the foetal heart minimises the danger of the former case, and the latter is of quite secondary importance.

In April vaginal operations were resumed, and there were 12 morbid cases out of 96 deliveries.

In May 119 women were delivered, with 24 morbid cases and 1 death. In that case fever set in on the fifth day, and she died on the fifteenth. On looking over the bed cards I found that one gentleman who had examined her had also examined two other patients the same day, both of whom became dangerously ill, but finally recovered. I accordingly prohibited his attending the hospital for one month, and again forbade vaginal examinations, excepting only in particular cases when they were made by myself or one of my assistants.

In June vaginal examinations were again permitted, but only by one student, my object being to increase the sense of personal responsibility. During this month 106 women were delivered. There were 21 morbid cases, but all excepting one were unimportant; that one died on the fourteenth day. We now returned to antiseptic douching,

but, in July, out of 110 cases there were 14 morbid, most of them severe, and 1 death. This patient had a normal delivery, and was not examined vaginally. Her convalescence was normal up to the fifth day, when her temperature rose to 102°. Her uterus was washed out with carbolic acid lotion, 1 in 40, and some putrid clots came away. She was again douched out on two successive days, but pyæmic symptoms set in, and she died at the end of a week. Towards the end of August there were seven cases of severe illness, and I again resorted to the plan which I had previously found so successful, namely, stopping vaginal examinations altogether, but on this occasion without the former good results. Two cases proved fatal. On September 2nd another woman was confined, and ultimately died. The first of these three cases had been examined by one student only. Her temperature continued normal up to the fifth day, when it rose to 104.4, with headache and shivering. The uterus was washed out, and the temperature sank to normal, and continued so until the eighth day, when she left the hospital, having signed a declaration that she did so contrary to our wishes. The same evening she had a rigor, and her temperature rose to 106°. A week later she was readmitted to hospital with pyæmia, of which she died six weeks from the date of delivery.

The second case was not examined vaginally. Her temperature continued normal up to the fifth day, when it rose to 110.4° F. Septic symptoms set in with diarrhœa, and she died on the fifteenth day.

The last case was delivered on September 2nd. Her labor was normal, and she was not examined vaginally. Her temperature continued normal until the fourth day, when she also became septic and died on the twenty-sixth day.

In considering these cases the following points were important: One only had been examined vaginally, and in all infection was late, and was due apparently to some error in the management of childbed rather than of the labors. The method adopted up to this time during convalescence was introduced by my predecessor, Dr. Macan. Each patient was given a basin night and morning containing water, and a large piece of tenax, and was directed to wash herself, the object being to prevent the carrying of infection from one patient to another by the nurse. It struck me that this method was faulty because it would be impossible for an ignorant woman lying in bed thoroughly to disinfect her fingers, and I therefore directed that the probationer who attended a patient during her delivery should continue to do so afterwards, washing her carefully twice a day, and using the same antiseptic precautions as if she were making a vaginal examination. Each patient was also to have her basin placed over her bed, and to have it carefully disinfected with corrosive sublimate, both before and after using it; they had previously been kept on a dresser, and washed with warm water. Since that date we have had upwards of 1000 deliveries in the hospital, but not one death from any septic cause, nor even one case that gave us anxiety.

I hope, gentlemen, that I have not wearied you with these minute details. I have entered into them to show that puerperal fever can be prevented, and that the cause is generally something so

obvious that when it is discovered we are surprised at our own blindness in having overlooked it. It is generally held that septic infection is uncommon in private practice, but this I believe to be a dangerous mistake, and the same precautions are as absolutely necessary in private as in hospitals.—*Abstract Brit. Med. Jour.*

AN ADDRESS

DELIVERED AT THE OPENING OF

THE SECTION OF SURGERY

At the Annual Meeting of the British Medical Association, held in Bournemouth, July, 1891,

BY JOHN WARD COUSINS, M.B. LOND.,
F.R.C.S.,

Senior Surgeon to the Royal Portsmouth Hospital, and
Portsmouth and South Hants Eye and Ear Infirmary.

RECENT ADVANCES IN THE TREATMENT OF TUBERCULOUS DISEASES OF THE JOINTS.

The Modern Pathology.—In the year 1882 the whole pathology of tuberculosis underwent a great evolution by the complete demonstration of the life-history of the tubercle bacillus. The disease occurring in any tissue of an organism must now be regarded as a specific disorder, the bacilli as the direct cause of all the morbid changes, and their presence as the distinctive sign of the disease.

Now, it is only by drawing a comparison between the old and the new pathology that we can really decipher the magnitude of the revolution in our conceptions. We no longer fight about the primary seat of the disease, for it is now certain that it may commence in any of the tissues of a joint. At the onset it may be synovial or osseous, and when the origin is in the latter structure it may select its surface or its substance. Strumous disease of the bones and joints is the same disease as tuberculous disease of the bones and joints; for in all these affections a specific deposit can be detected. Tubercle bacilli are never found but in this special product, and wherever the tuberculous tissue is discovered this microbe has obtained a resting-place. Their number may vary in the diseases of different structures, and also at different periods of the same disorder; still, when only a few are present they will be found by careful scrutiny.

The new pathology of tubercle is sustained by a mass of evidence derived from microscopic research, the artificial cultivation of the parasite, and experimental inoculation, so that the old notions which had long surrounded the disease have been numbered with the things of the past. The long-accepted causes, too, have been dislodged from their position, and are rightly grouped as morbid tendencies. The inheritance of constitutional peculiarities, the liability to chronic inflammations, and the susceptibility to external influences, are thus regarded as essential conditions, which help the microbe to establish itself within the body. Still, these factors are not less potent because the specific character of tuberculosis has been recognised. Hereditary proclivities and physical peculiarities of structure have not fallen into insignificance, but in their new position it will be possible to better estimate their potency.

Arrest Possible in the Early Stage.—The modern pathology of tuberculosis has already exercised a salutary influence over surgical treatment and the progress of conservative surgery. Its distinct recognition as a specific and infectious disorder, in all its various manifestations, has placed the hope of arrest on a very different basis to that which it previously occupied under the old constitutional theory. During the early stages of joint disease the morbid action is often localised, and, therefore, arrest is at least possible. There can be no reason why a joint or a bone should not recover, and the tuberculous infiltration atrophy, and ultimately shrivel into a fibrous scar, just like a similar deposit in the apex of a lung. If the number of bacilli found by microscopic examination in a part are to be taken as any indication of the activity of the disease, then repeated observations are favorable to the conclusion that incipient disease in the articulating apparatus is more hopefully situated than incipient disease in the pulmonary tissue.

A few years ago strumous children laboring under chronic joint disease were kept in bed for many months, but now expectant treatment can be carried out more hopefully by combining rest and protection of the limb with fresh air and exercise. The management of incipient joint disease has fortunately undergone a silent revolution through the mechanical genius of the late Hugh Owen Thomas, of Liverpool. His surgical appliances are admirably adapted for taking off concussion, arresting friction, and imparting support and protection without pressure; at the same time they are so simple in construction that the patient can adjust them without assistance. Thomas's splints have been utilised by surgeons in all parts of the world.

Tuberculin.—When, a few months since, the celebrated announcement reached us that a new remedy had been discovered which possessed the remarkable power of causing the necrosis of living tuberculous tissue, a new method of arrest appeared probable in recent cases, and material improvement in others of greater severity which would prepare them for surgical treatment. Although I have used the remedy in many cases of joint and bone disease without decided benefit, it will still receive from me a full and impartial trial. It is certain that it contains an agent which is capable, even in an infinitesimal dose, of exciting active changes in the body containing any traces of active tuberculosis. In the chemical aspects of microbial life, and in the complex bodies which are formed by the artificial cultivation of the bacilli themselves, we discern the direction from which we may anticipate future discoveries. I regard the search for a remedy amid the growth of these living particles as a splendid effort to reduce the magnitude of a world-wide pestilence, for which, up to the present moment, no really scientific treatment has ever been propounded. The great German investigator has not yet finished his work; let us patiently wait for his results, and keep ourselves free from prejudice, hoping that his daring assault upon the most deadly of diseases may ultimately be crowned with success.

Early Efforts.—Until the last few years, early operations in joint disease had scarcely received any attention. In 1878, Volkmann, the inventor of the cutting spoon, performed several partial excisions in recent cases of hip-joint disease, but his results did not stimulate him to further trials.

Since the year of the pathological revolution (1882) many favorable cases have been recorded, and I feel confident the practice, although still regarded by some as experimental, has already saved many limbs from graver operations.

Advantages of Early Operation.—Whenever the indications for surgical interference are clear, early operation must be attended with many advantages. The only hope of cure must depend upon the complete removal of the diseased tissue, and the facility with which this can be accomplished rests entirely upon the extent of the local mischief. The preservation, too, of useful mobility in the joint may be anticipated when the morbid process is well localised.

Partial Arthroctomy.—For the successful performance of a partial arthroctomy there must be clear evidence of a localised deposit. In some cases children have exhibited very little pain or lameness, but the joint has been in some part swollen, with the capsule thickened and the bones enlarged, but without any indication of softening or suppuration. By a well-directed operation, near the neck of the femur or the head of the tibia, search has been made for a spot of tuberculous infiltration, with the result that a carious cavity has been found and small sequestra successfully removed.

Another recommendation for early arthroctomy is the little danger that attends the operation. After a full incision in the most convenient position for exploration and carefully defining the disease, the infiltrated tissue must be excised with the scissors or cutting spoon, and the cavity thoroughly flushed with hot water.

A few months since I performed arthroctomy on a child for acute infection of the knee-joint. In 1889 the little patient was under my care, in the Royal Portsmouth Hospital, laboring under a small sub-periosteal abscess over the head of the tibia, close to the reflection of the synovial membrane. The swelling was freely incised, and a considerable deposit of caseous material cleaned out with the spoon. The bone was roughened perilously near the articular edge, and the parents were specially warned of the danger. Soon after the child left the hospital the swelling slowly recurred without either pain or lameness. In the month of July last she hurt her knee during a game of play. Acute pain immediately followed the accident, attended with rapid swelling of the joint and fever. Three days after, she was readmitted to the hospital under my care. The knee was at once freely opened on both sides, and the inner incision was carried through the abscess cavity through the head of the tibia. The capsule contained about three ounces of a turbid fluid with many flakes. The infiltrated synovial membrane was freely excised with scissors, the joint thoroughly cleansed, and the limb carefully placed on a back splint. Irrigation was continued for a week. The child was discharged quite well in January. The movements of the knee are now normal, a result due to immediate treatment and the limited injury of the synovial membrane.

Complete Arthroctomy.—Permit me now to offer a few remarks on the surgical treatment of more advanced cases in which the morbid process is too extensive for any partial operation. In the performance of complete arthroctomy a free division of the ligaments and capsule is necessary for the

exploration of all the recesses of the articulation, and the excision of deep infiltrations of the synovial and osseous structures, so that the preservation of only a limited mobility must be anticipated. The whole of the pulpy granulation tissue must be dissected off, and the ligaments and cartilages carefully scraped. It is absolutely necessary to remove every particle of the diseased synovial membrane, and all tuberculous foci in the bones must also be cleanly cut out with the gouge. Care must be taken to prevent any remnants of the infective tissue being left behind on the raw surfaces, and the accidental reinoculation of the disease through the medium of the fresh incisions. I regard the method advocated by Mr. Arthur Barker, of flushing with hot water the seat of operation, to be the best way of carrying out these important precautions, and for the rapid performance of this part of the operation his ingenious scoop and irrigator will be found of great practical utility.

Surgical Treatment in the Advanced Stage of Hip Disease.—With reference to the old method of operating in the advanced stages of the disease, after suppuration has been proceeding for months, and sinuses have long riddled the soft parts, and when the unfortunate patient has been exhausted by a general tuberculosis, I sincerely hope it will soon be cast into the shade for ever by the light of modern progress. It is my experience that these distressing cases recover more frequently by simple measures, consisting of free incision, scooping, irrigation, and drainage, and that the ultimate results are more satisfactory than those which follow the practice of severe and dangerous operations.

In reviewing the progress of the past we must not give way to wonder and surprise, but rather calmly cultivate a spirit of confidence and anticipation, and be ready to accept fresh light from whatever quarter it may fall upon us. May we, like Sir Benjamin Brodie, desire, above all things, the attainment of the truth, and be ready to pulverize our most cherished convictions, and to cast them away for ever, when truth and progress demand of us the sacrifice.—*Abstract Brit. Med. Jour.*

AN ADDRESS

DELIVERED AT THE OPENING OF

THE SECTION OF THERAPEUTICS

At the Annual Meeting of the British Medical Association, held in Bournemouth, July, 1891,

By WILLIAM VICARY SNOW, M.D. LOND.,
M.R.C.P.,

Senior Physician to the Royal Victoria Hospital and the National Sanatorium, Bournemouth.

In consequence of our more accurate knowledge of disease, and especially of those affections attended by febrile phenomena, since the introduction of the clinical thermometer much progress has been made in therapeutics. We have been able to more correctly estimate the action of remedies, not only in health, but in disease, and hence treatment has become more scientific and rational.

In specific disease we have learnt that it is not only the micro-organisms present which have to be considered, but that it is probable the chemical changes they set up play a most important part in

causing the phenomena of disease. It is well-established that certain zymogenic organisms give rise to a chemical product inimical to their own growth, and when of a certain strength sufficient to stop the process. The mortality from consumption is now in England not more than one-half of that existing during the first fifty years of this century, while the death-rate from this disease has increased in many countries. This grand result has been obtained by improved methods of treatment, sanitation, improvement in the workshops and dwellings of the laboring population, and especially by the subsoil drainage of towns.

At the International Medical Congress last year, it was announced by Koch that a remedy had been discovered which conferred on the animals experimented on an immunity against inoculation by the tubercle bacillus, and which would arrest tuberculous disease, and that the remedy would be tried on human beings.

Before the injection of tuberculin can be adopted as a recognised method of treatment for consumption, the following question must be answered in the affirmative: Can this treatment be carried on with reasonable safety? In very weakly patients and those with extensive and advanced disease, such a treatment must be attended with risk, and it is not surprising to hear that fatal results have directly followed the injection of tuberculin. The ten cases treated at Ventnor, the similar number treated in the Sanatorium, coupled with the experience of Dr. Coghill, at Ventnor, in private practice, and my own, inclines me to believe that tuberculin may be safely used in cases judiciously selected, under favorable circumstances. I will now as briefly as possible call your attention to the only three cases I treated in the Sanatorium in the year 1890, and I do so because I have been able to trace the results over a period of seven months from the first injection.

E.M. was admitted on November 6th, 1890. She had lost three sisters from consumption and other relatives; had been ill more or less for three years, and had had one attack of hæmoptysis. Her afternoon temperature ranged from 99° to 100°. The expectoration measured one-half ounce, was mucopurulent, and contained bacilli. The resonance was imperfect at the apex of the right lung, and the respiration bronchial; the left lung was affected to a less extent. The treatment was commenced on December 6th and completed on January 30th. Twenty injections in all were given. The patient had lost four pounds in weight in the previous fortnight, and lost six pounds more during the first four weeks of treatment. On January 30th the patient had very little cough or expectoration; did not react to 0.01 cubic centimetre, but bacilli were still present. She continued to steadily improve, and left the hospital on April 21st, having lost all cough and expectoration, and gained twelve pounds in weight from the lowest point. Her temperature was normal, and, on examination, the physical signs were found to have improved. The last expectoration contained no bacilli. She had been previously living at home without occupation; she now writes—July 2nd—that she has remained perfectly well, and has entered domestic service as nurse. As the patient was losing weight before, and for a month after, the commencement of the treatment, and had an exceptionally bad family

history, and as no symptoms of relapse have been observed up to seven months from the commencement of treatment, I think we may fairly claim that the disease has been arrested; no case of consumption can be considered cured until all symptoms have ceased for two years.

A.D. (dressmaker), æt. 18. Admitted Nov. 3rd. Duration of illness nine months. A sister consumptive. Had gained two pounds in weight before treatment commenced on Dec. 6th. Beyond slight dullness and prolonged expiration at the left apex, no physical signs existed; the expectoration was scanty, and contained a few bacilli; evening temperature, 99.8°. Eighteen injections were given, but, in consequence of the severity of the reactions (104.8°), the amount was not carried above 0.005 cubic centimetre. January 30th: Patient feels perfectly well, has no expectoration or cough, and has gained five pounds. Physical signs unchanged. She continued to improve and gained from the commencement of the treatment twelve pounds, and was discharged on April 22nd. She writes, July 2nd: "I think I am about the same weight as when I came home, having neither cough nor expectoration, nor do I perspire at night; I am also able to follow my employment without difficulty." You will observe that tolerance of the tuberculin could not be established, and that the amount of the disease was very slight. It is quite possible that to the change of climate and rest from work the improvement is due.

W.H. (footman), æt. 23. Three years before pleurisy with effusion, expectoration one-half ounce; muco-purulent, containing numerous bacilli. Considerable consolidation existed at the apex of the right lung, weak breathing was noted at the base, and dry friction in the right axilla. The left lung was only slightly affected at the apex. Sixteen injections were given from December 4th till January 17th, and then discontinued in consequence of a very severe attack of dyspnoea. Three times the expectoration was stained with blood; six times dyspnoea was noted. The febrile reactions were moderate. The treatment was resumed with a fresh supply of tuberculin on February 17th, and continued until March 19th; no reactions followed the use of 0.01 cubic centimetres; the patient was discharged on April 9th. He was feeling much better. The percussion note had improved and the breathing became more vesicular. The temperature was normal and the cough and expectoration slight. No bacilli could be found in the expectoration. He gained four pounds in weight before the treatment was resumed, and during it lost three pounds. He shall speak for himself as to his after-progress in a letter to the lady superintendent, June 12th:

MADAM,—I am very pleased to tell you I have improved in health very much since I left the Sanatorium. I have gained in weight seven pounds, and I have been in work a fortnight now, and able to do it with pleasure, and feel it only right for me to let you know the good I got at the Sanatorium through Dr. Koch's treatment. I have hardly any cough, and I get no pains at all.

Subsequent reports confirm the improvement in this case.

The treatment was carried out with the antiseptic precautions recommended, and no evil consequences followed the punctures. The patients

were placed under the best hygienic conditions possible—kept in bed during the febrile reactions, and fed mainly on a milk diet.

Stimulated by Koch's discovery, the inventive faculty of the profession has been at work, and, as I write, new methods of treatment are under trial, especially in Paris. May they be tried under more auspicious circumstances, and not prematurely introduced. Whether this discovery be a success or a failure, I feel that a line has been indicated pregnant with grand results, not only for the arrest of consumption, but also for the treatment of other diseases.—*Abstract Brit. Med. Jour.*

Selections.

OFFENSIVE LEUCORRŒA ASSOCIATED WITH ACUTE ANTEFLEXION.

BY GRAILY HEWITT, M.D., F.R.C.P.,

Emeritus Professor of Obstetric Medicine. University College.

The following case is one of great interest, both from a theoretical and from a practical point of view. A.B., single, aged 27, was brought to me for consultation on October 8th, 1890. She is a general servant, and has worked extremely hard. She is very conscientious, and during the last year she has frequently sat up at night to do extra work; namely, washing. During the last two years her health has been failing. The symptom which is the most distressing is the presence of a terribly offensive odor and discharge from the vagina. This has existed for nearly two years, being always very much worse during the week following menstruation. She is now obliged to have repeated change of linen, and the greatest difficulty is experienced in getting rid of the offensive smell from the rooms used by the patient. She looks ill and pale, there is pain at the epigastrium, also pain in the pelvic region, and she can only sit on the edge of a chair. On examination it is found that the uterus is large and broad, and anteflexed. The body of the uterus forms a retort-shaped mass, which lies low down behind and below the symphysis pubis. By means of the sound the uterus can be straightened, but doing this occasions much pain. The size of the uterus is that of a small orange.

The diagnosis formulated was: retention of menstrual *débris* with decomposition of same due to a pouched anteflexed uterus.

Treatment: Insertion of a cradle pessary and plenteous carbolic injections of hot water. Diet: Milk in large quantity.

October 15th. Much better as regards pain and offensive leucorrhœa. October 31st. Very much better. Wearing cradle, which controls the position of the uterus satisfactorily. The last period more as it should be. Has now begun to do a little. April, 1891. The offensive discharge has now ceased, the position of the uterus good. Local treatment continued. Takes food well, and in all other respects material improvement.

Whatever view may be taken of the above case, it is the fact that the reposition of the uterus at once produced an alteration in the vaginal discharge. The patient had previously been treated by injections, etc., unavailingly. By elevation of the body of the uterus the contents of the organ (retained menstrual products) more easily escaped, and their decomposition was prevented. The intensity of the ante flexion in this case was very noticeable, and I have never seen such acute ante flexion except in cases where very unusual exertion or a violent shock from an accident had been experienced. It is my belief that retention of menstrual products in cases of acute ante flexion is common. The rarity of the case above related is the long-continued putrescent character of the discharge.

The explanation of the putrescence is probably the detention of menstrual shreds in the cervical canal in contact with air passing into the vagina, or even possibly passing into the uterus. As regards the presence of air in the vagina, it occurs to me to mention that some years ago I saw a case in which, whenever the patient sat down to table, flatus was expelled from the vagina in the most annoying manner. It was found that the uterus was large and heavy, and markedly ante flexed. The vagina was distended like a ball. The opinion formed was that the air entered the vagina consequent upon exaggeration of the displacement, and a sort of suction action set up thereby. At all events the reduction of the ante flexion put an end to this disagreeable symptom. There was no such escape of flatus in the case above related, but the putrescence implies rather free admission of air into the vagina, which admission was probably favored by the ante flexion.—*Brit. Med. Jour.*

JOHN HUNTER is said to have been a "little man," being only 5 feet 2 inches high.

SULPHONAL POISONING.—This drug was introduced about three years ago as a safesoporific. Since that time reports have been published concerning its safety and efficacy, many speaking highly in its favor, but the poisonous dose could not unanimously be agreed upon. We have many cases on record where about three teaspoonfuls have been taken to obtain sleep; one of these is reported to have slept four days and four nights, awoke a short time, and then went to sleep another half day; he then got up, felt a little giddy, but beyond this no other trace of the drug remained. Another case is recorded where a man wanted to have a good sleep, and took about 30.0 grammes of sulphonal, went to sleep as desired, but never awoke. A more unusual case is now recorded by Dr. Ernest Neisser. A lad about fifteen years, chemist's assistant, desirous of making away with his own life, swallowed the contents of two boxes, containing fifty grammes each, making a total of one hundred grammes of fine pulverised sulphonal. He took the greater part of the two boxes in a solution of water, and left home, taking the remaining part dry, which he swallowed about three-quarters of an hour afterwards. He was found six hours later in an unconscious condition, and forwarded to an hospital, where he lay five nights and days perfectly unconscious. On the sixth day he began to awaken, and on the ninth day he left the hospital perfectly well. In this enormous dose we have a wider disparity than ever, when we find a strong healthy man dying from the effects of thirty grammes, while a lad of fifteen swallows one hundred grammes, awakes after six days and finds himself quite well.—*Med. Press.*

VASELINE AS A VEHICLE.—Carles thinks that benzoinated lard, as it is more easily absorbed, is a better vehicle than vaseline. Dulrenith admits that there are cases in which vaseline is much superior. Some substances, which quickly change when in contact with fat, are well preserved in vaseline, e.g., mercury. The ointment of corrosive sublimate, or of the red oxide of mercury, is hard to keep when made with fat. Some drugs act in different ways, according to their vehicle. Thus, ichthyol, mixed with fat, has a powerful influence on certain skin lesions, diminishing the inflammation; whilst, made up with vaseline, it acts but superficially. When

absorption of the drug is not needed, vaseline is to be preferred, for it is also a great antizymotic. As vaseline is not absorbable, it offers advantages of no small value. Lard is quickly absorbed by the epidermis, which then dries, and cutaneous evaporation is not impeded. Vaseline does not dry; forms a tenacious impermeable varnish, underneath which the skin macerates. After two hours friction with fat, the skin is dry, whilst vaseline resists a whole day.—*La Cronica Médica*.

RECENT RABBIT DEVELOPMENT.—An article in the *Hobart Mercury* of May 4th gives some very interesting and curious facts concerning the development of a new sort of nail in the rabbits of Australia, in consequence of the animal's endeavor to climb over the wire netting used to impede their progress in travelling. The farmers have discovered that the rabbits can burrow under the netting unless it is buried some six or eight inches under the soil. Moreover, they can climb, or evidently intend to do so, after a little training, and to this end they are developing a nail which will enable them to hold on while progress is made upwards. This nail development has been noticed before, in Queensland, when the bark just out of reach was desirable of attainment, but to effect hand-over-hand nautical climbing shows the rabbit in the act of elevating himself in the scale.—*British Medical Journal*.

COCONUT BUTTER.—Coconut butter must not be confused with cacao butter. It is prepared from the kernel of the coconut, and is a white, odorless, and practically tasteless fat, melting at about 26°C. It appears to be distinguished by a high saponification degree, and by resistance to decomposing influences, including bacteria, for the development of which it does not form a suitable nutrient medium. This fat appears also to be much more easily digested than ordinary butter or lard; at least, this was indicated by artificial tests, and believed to be confirmed by the statements of patients "suffering from every form of dyspepsia," who were able to take it without experiencing any unpleasant symptoms. The "butter" is being produced in large quantities, and its economic value would seem to be already established.—*The Monthly Magazine of Pharmacy, etc.*

ALCOHOLIC SINGULTUS.—Dr. Smart reports the case of a man who, for several weeks, suffered from alcoholic singultus, and in whom recovery took place after collapse. The hiccough was severe and continuous, at the rate of sixteen per minute. The treatment adopted was washing out the stomach and feeding per rectum by enemata and suppositories. Morphia was administered hypodermically every three hours, a little chloroform being given, either in the form of the spirit or by inhalation, a little before each dose of morphia. Treatment began to do good in about thirty-six hours, when the hiccough diminished by about one-third. On the fifth day it ceased altogether, but the treatment was carried on for three days longer.—*Med. Press*.

No less an authority than Dr. Hughlings Jackson is responsible for the following: At a professional dinner party in London the conversation turned upon the subject of the remarkable development of specialism in the past few years. One of the gentlemen present declared that it had reached such a pitch that every possible portion or subdivision of the human body had now doctors and hospitals devoted solely to its treatment, except the umbilicus. He was, however, compelled to withdraw even this exception on being promptly reminded—we suspect by Dr. Jackson—that there were in that very city several *naval* hospitals.—*Vis Medicatrix*.

I THINK many of our examining boards have met this school boy at a somewhat maturer stage of his development. He was requested to briefly name and describe the divisions of the human body and the contents of each. "The body is divided into three cavities—the head, thorax, and abdomen; the head contains the brains, when there is enny; the thorax contains the lungs, liver, and diafram; the abdomen contains the bowels, wich is five in number, *a, e, i, o, u*, and sometimes *w* and *y*."

HOSPITAL SUNDAY.—The institution known as "Hospital Sunday" existed on the continent for a long time, but was only introduced into England in 1873, when Dr. James Wakeley, editor of the *Lancet*, started the Metropolitan Hospital Home Fund. Up to July 20, the fund this year had reached a total of \$208,000.

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.

When a change of address occurs please promptly notify the Publishers, THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, AUGUST 17, 1891.

THE MEETING OF THE BRITISH
MEDICAL ASSOCIATION.

In years past we have often referred to the British Medical Association as the greatest medical society that the world has ever seen. Its membership has reached the enormous number of 13,800, and is rapidly increasing (an error as to the number appeared in our last issue). Branch societies are being formed in various parts of the Empire. We referred recently to the three branches lately formed in Canada. The last meeting at Bournemouth, July 28 to 31, was largely attended and highly successful.

Through the kindness of the editor of the official organ of the Association (*The British Medical Journal*), we have received proof sheets, in galley form, of many of the addresses delivered at the meeting. We are taking a considerable space in this issue for the publication of abstracts of a number of these. Although at the time of writing *The British Medical Journal* containing these addresses had come to hand, still without the assistance referred to we would not have been able to give any portion of the addresses in this issue. Our abstracts, which in some instances are chiefly extracts, will be found interesting; but, of course, they cannot do full justice to the authors. We know of no better way of giving our readers an idea of the magnificent work that is done at these meetings, and if we could induce them all to make it a point to read and study carefully all the addresses, papers, and accompanying discussions, as they will be reported from time to time in *The British Medical Journal*, we feel that we would be doing good service.

The recent formation of the branch societies in Canada will do much to make our physicians take a greater interest in this grand organization, and will tend to give our friends in England, Ireland, and Scotland, a more intimate acquaintance with us. It is generally admitted that the success of the Association is largely due to the work of Mr. Ernest Hart, who has shown singular administrative ability in his management of all matters placed under his charge. He is particularly interested in the formation of branches in all parts of the British Empire. We sincerely hope our Canadian branches will be *active*, not passive, supporters of the mother society.

TUBERCULIN.

We hear but little of Koch's lymph now, but there are a number of able physicians and surgeons who still have faith in the efficacy of the remedy. In addition, it is probable that the majority of the profession in all parts of the world believe that the distinguished German has made discoveries which will produce grand results in the near future.

In THE CANADIAN PRACTITIONER of July 16 Professor Ramsay Wright published a short paper on the dosage of tuberculin, in which he referred to the work of Guttman and Erlich at the Moabit Hospital in Berlin. The doses are much smaller than those formerly administered, and the results reported are very encouraging. It is certainly fortunate that the dosage has been changed in the right direction, because the great reduction removes, to a large extent, the grave dangers formerly connected with its use.

Recent reports from various quarters indicate that the quality of the remedy is much improved, and better results are being obtained on that account. It is fortunate that the reaction which followed the intense excitement of a few months ago has obliterated the feverish interest which the public manifested in the so-called "cure." Semi-theatrical exhibitions in certain parts of the world are not likely to be repeated. Scientific practitioners can watch its effects with calmness and deliberation.

We are pleased to notice that the physicians and surgeons of Great Britain, who are generally conservative and wonderfully level-headed about things new in medicine, have not agreed on a verdict against the remedy. On the contrary,

we learn from the records of the recent British Association meeting that many able and careful men are using the tuberculin with very satisfactory results. We have an idea that the next year will bring forth evidence to show that Professor Koch has discovered a remedy which will be of great value in the treatment of phthisis.

Meeting of Medical Societies.

PATHOLOGICAL SOCIETY OF TORONTO.

April 25th, 1891.

The society met in the Biological Department of the University of Toronto. The President, Dr. J. E. Graham, in the chair.

NECROSIS OF THE CALVARIUM.

Dr. Peters presented a specimen from the head of a child ten months old, who fell off a chair on a piece of coal, causing a scalp wound and laying bare the bone. Three weeks later the patient came to the extern department of the Toronto General Hospital, and was seen by Dr. Peters. At that time there was a large amount of swelling. Three openings were made but very little pus exuded; the bone was bare. After some weeks the bone appeared to be loose; so an operation was performed, and the sequestrum removed. A portion of the dura mater about two square inches in extent was exposed, covered by a gelatinous tissue, which was scraped away. Healing took place slowly. At intervals during convalescence there were some symptoms of cerebral irritation, and later there were fifteen fits in one day. The child was teething, and he thought the fits were due to that. Since the wound has completely healed there has been one fit. The part from which the sequestrum was removed is quite firm, and apparently new bone has formed. It is interesting to observe how much the dura mater will bear.

Dr. McPhedran read the following history:

PERNICIOUS ANÆMIA.

R.P.E., æt. 36. Barrister. Had always been a hard-working student, and had met with many reverses. Had always been healthy until two years ago, when he had diarrhœa with jaundice. Recovered in about two weeks. About six months later he noticed that he was losing color,

but paid no attention to his condition. He attended to his professional work regularly until about a month before his entrance into the Toronto General Hospital, March 8th, 1891. There he was extremely pallid, with a lemon-yellow tint. The conjunctivæ yellow from fat and œdematous; eyes quite protuberant. There was abundant subcutaneous fat. He was very weak, and his mental condition was not clear. He had diarrhœa, with frequent light yellow stools. Pulse small and weak; apex beat of heart diffuse; hæmic murmurs at base. The veins, especially on the backs of the hands, of a magenta color. The liver and spleen did not seem enlarged, but could not be accurately delineated. The urine was at first scanty; later, more abundant; fairly high-colored; sp. gr. 1012, no albumen. Blood contained about 700,000 r.c. per cmm.; no rouleau; corpuscles small, large, and irregular; the largest 12 μ . Temperature varied between 99° and 101°; there were no paroxysms. There was considerable pain in the abdomen and diarrhœa persisted; there was also occasional vomiting. On March 16th there was profuse epistaxis. On the 17th he died.

At the autopsy, an abundance of subcutaneous fat was found, and there was marked fatty condition of all the organs.

The condition found *post mortem* was then further described by Dr. John Caven.

Dr. John Caven presented specimens from a case of pernicious anæmia, and read report of *post mortem* examination.

Post mortem examination of the body of R.E., T.G.H., March 18th, 1891.

Inspection: Shows body of a male; apparent age, 35; general nutrition fair; rigor mortis fairly marked; *post mortem* staining almost nil; waxy-yellow color of skin; blood, crusted in ant. nares and mouth; eyes, very prominent, sclerotic yellowish, medium dilation of pupils, small subconjunctival hemorrhage on left eyeball, external orifices all right.

Section: Shows a large quantity of very yellow subcutaneous and subperitoneal fat; muscle very pale.

Pericardium and Heart: Three fluid ounces serous fluid in sac; no ecchymoses; one small milk spot over right ventricle, peri- and epicardial otherwise normal. Heart weighs fourteen and

a half ounces; covered deeply over right ventricle with fat. Right ventricle hypertrophied to one-quarter inch average thickness; also dilated. Left ventricle hypertrophied to three-quarters inch average thickness; dilated also; very beautifully marked fatty degeneration of muscle of internal surface of left ventricle and of papillary muscles; this condition not visible in right ventricle; malformation of aortic valves; two cusps continuous with low septum behind middle; edges and bases, thickened; valves, quite competent; mitrals, all right; auricles, foramen ovale, closed; walls, thin and dilated.

Aorta: Reddish staining of intima, as in septicæmia; vessel, very thin, and of small calibre.

Pleuræ and Lungs: Pleuræ of left side completely adherent, showing very distinct parallel fatty bars; slight calcareous deposit in adhesions to diaphragm. Left lung, very pale and œdematous. Pleuræ of right side, no adhesions; two and a half ounces of reddish serous fluid in cavity. Right lung, upper lobe shows marginal and apical vesical emphysema; hypostasis and œdema in lower lobe.

Omentum and Peritoneum: Very pale; much fat in omentum.

Spleen: Large, fourteen ounces; tarry black; soft, almost diffluent.

Kidneys: Each five ounces; large, very fatty; demarcation between cortex and medulla almost lost.

Ureters, Bladder, and Prostate: Healthy.

Supra-renals: Healthy.

Intestines, small and large: Very pale, distended with gas; slight catarrh; muscular coat thin; a few small hemorrhages into mucous membrane of jejunum.

Appendix Vermiformis: Four and a half inches long; lumen contracted till it appears like a fibrous cord, white and dense.

Duodenum and Stomach: Bile ducts, patent; catarrh of stomach; a digested patch in mucous membrane on posterior surface, close to cardia, size of a ten-cent piece; a few small petechiæ in mucous membrane.

Esophagus: Healthy.

Liver: Four and a half pounds; pale, yellowish-red color; fatty; no lobules distinguishable; anæmic gall-bladder contains a small quantity of thick yellowish bile and mucus; ducts and veins, healthy.

Pancreas: Large, healthy.

Brain: Membranes, pachymeningitis interna plastica over frontal regions and vertex; firm plastic exudate firmly adherent to inner surface of dura mater; a few small points of hemorrhage into dura mater; considerable serous fluid in subarachnoid space. Brain, pale, firm; puncta vasculosa, poorly marked; nothing else visible noteworthy.

Orbit opened, and bulging of eyes found to depend upon a very large deposit of fat behind eyeball. Retina, very red, but no hemorrhages visible.

Microscopic Examination:

Heart: Muscle, extreme fatty degeneration.

Liver: Cells, swollen and smooth-looking, most containing finely granular, yellowish-brown pigment nuclei, often very large and vacuolated; cells, occasionally vacuolated also; interlobular connective tissue infiltrated with small round cells; capillaries much narrowed in places, and containing many nucleated cells, mostly uninuclear; sometimes three to five nuclei, occasionally large cells, with seven or more nuclei. Endothelial cells of capillaries swollen very greatly in places, and rarely containing within them small round cells, apparently leucocytes; large roundish cells in capillaries, containing brownish granules in large quantities.

Kidney: Cells, granular and fatty.

Dr. Macallum asked if sections of the kidney and other glands showed like endothelial hypertrophy. The alcohol is apt to extract the iron.

Dr. Caven had not found any enlarged endothelial cells in the kidney, but the cells lining the tubules were, in some places, reduced to a granular debris, and pigment was visible.

Dr. Graham asked if there was any striking want of blood in the vessels *post mortem*.

Dr. Macallum said the liver sections show very strikingly cell hypertrophy; this seems to point to the fact that pernicious anæmia is occasioned by absorption of a poison affecting the cells. It has been found that the poisonous extract of the germs of diphtheria and scarlatina injected hypodermically produced hypertrophy of the cells in the liver, and a certain amount of leucocytosis. An endothelial hypertrophy of the kidney occurred after injecting scarlet fever poison. It looks as if the poisons are capable of producing these results; they have also given rise to abscesses.

Dr. Graham referred to a case occurring five weeks after pregnancy, where the temperature was 101.2° F. The patient had done well after confinement, but then became weak. He thought it might be pernicious anæmia; but he found in one breast a mass of fluid, and evacuated a pint and a half of pus. There had never been any pain, rigors, etc. A few days after, the other breast went the same way, and in a day or two the patient died. It did not seem like an ordinary case of pyæmia. He wondered if the case had anything to do with extreme leucocytosis. The blood was examined, and the red cells were irregular in shape, and the white cells seemed to be dividing.

Dr. Caven said the leucocytosis in these liver cases was not to be compared to abscess formation. The mononucleated leucocyte is found in leucocytosis without pus formation. Pus cells are dead white corpuscles.

Dr. McPhedran asked whether pernicious anæmia is a specific disease or symptomatic merely. The question as to whether free iron is present or not is not settled. Is the poison referred to by Dr. Macallum as producing pernicious anæmia of a special variety, or is the anæmia simply symptomatic of the action of a variety of poisons? He referred to a case in point in which there was a doubt as to the diagnosis.

Dr. Macallum did not wish to be understood as holding that pernicious anæmia was due to absorption of a particular poison. Pernicious anæmia is a term used to describe a disease due to a variety of causes, having been found to result from syphilis, tuberculosis, etc. There may also be anatomical causes which produce pernicious anæmia.

CONJUNCTIVAL TUMORS.

Dr. R. A. Reeve presented two specimens.

(1) The first was a recurrent growth in a man past middle life. He was seen five years ago, and a growth from the conjunctiva and cornea was removed. It recurred two years later, and again, a few months ago, a third growth was removed. It was pale red, covering the superficial area of the cornea, implanted on the sclerotic conjunctiva and part of the outer part of the cornea. It was not firmly attached to the surface of the cornea, but could be undermined at the edges. The tumor looked like a

compromise between a granuloma and a papilloma. Dr. John Caven had found it to be composed of a mass of cells with little or no connective tissue. This would point to granuloma. He would expect from the history of the tumor to find it a sarcoma, but apparently it was not.

(2) The second case was one which looked sarcomatous—a growth extending from the conjunctiva and outer half of the cornea, thus damaging the sight, a serious matter for the patient, as it was the only eye that was functionally active. The tumor was dissected off and the cornea scraped perfectly clean, all the affected surface being removed. The cornea was quite vascular at one place, and bled freely. The wound healed readily without inflammatory reaction. He hoped this tumor was not really sarcomatous, but chiefly fibrous in character.

Formerly it was thought that these growths sprang from the cornea, but now they are all thought to grow from the limbus, and therefore are properly called conjunctival tumors.

Dr. Caven described Dr. Reeve's sections.

(1) In gross appearance looked like a minute papilloma. On section nothing but polyhedral epithelial-looking cells could be found, with no fibrous tissue.

(2) This tumor seems to be sarcoma. There are spherules of hyaline-looking material characteristic of cylindroma. The nuclei stain evenly throughout, and have not the vesicular appearance of epithelium.

PYOSALPINX.

Dr. Barker presented a specimen and read the following history:

M. H., female, æt. 24; admitted to Toronto General Hospital on April 11th, 1891, with following history: Always fairly healthy until one year ago, when she was in Toronto General Hospital suffering from some form of pelvic inflammation, said to have been "metritis." She was unmarried, but had been living a fast life at intervals; history of syphilis. About two weeks before admission she felt severe pain in abdomen; consulted a physician and improved under treatment; some days later a gentleman friend spent the evening with her, and as a result there was a recurrence of the severe abdominal pain, together with elevation of tem-

perature and general prostration. On admission her temperature was $103\frac{1}{5}^{\circ}$, respiration 26, pulse 108; complained of great pain in lower part of abdomen, particularly in right groin; vagina hot and tender, uterus fixed; foetid discharge from vagina; boggy mass at right of uterus; too much tenderness to examine carefully, no anæsthetic being used.

Morphine and hot applications ordered, vaginal carbolic douches, together with milk diet. Temperature next few days, $100-102^{\circ}$; pulse, 100-120. On third day became delirious at times. On the evening of April 15th she complained of great increase in pain; abdomen distended; temperature $104\frac{2}{3}$, pulse 120; quinine in large doses ordered every two hours. Next morning temperature $97\frac{2}{3}$, respiration 30, pulse 98. At 11 a.m., she vomited and suffered marked rigor, lasting some twenty minutes, the pulse going to 134, perspiration profuse. At 2 p.m., temperature $103\frac{1}{2}$, respiration 50, pulse 140. Next morning temperature $102\frac{2}{3}$, respiration 60, pulse fluttering; died at 11 a.m.

Post mortem.—Examination of pelvic organs alone allowed. Uterus tubes and ovaries bound down in a mass of inflammatory tissue. Right ovary indistinguishable; large pus sac communicating with right Fallopian tube, running also into large sac behind uterus; would contain 6 to 8 ozs. Perforation of sac, contents escaped into peritoneal cavity; septic peritonitis; uterus adherent to bladder in front and rectum behind.

UTERUS AND FIBROID REMOVED BY VAGINAL HYSTERECTOMY.

Dr. Cameron presented a specimen from a patient who, some months ago, was suffering from a small fibroid with inverted uterus. For some time she had phlebitis in the legs, which delayed the operation for some months. The *ecraseur* was used to remove the tumor. It was doubtful whether or not the body of the uterus was removed along with the growth. The patient died uninterruptedly well.

TUMOR OF THE PONS VAROLII.

Dr. John Caven presented a specimen and said there had been bulbar paralysis followed by slight hemiplegia. On *post mortem* examination a tumor was found in the pons; there was symmetrical enlargement, the medulla be-

ing broader than normal. The anterior part of the pons for a quarter of an inch was normal, the tumor occupying the posterior portion. The basilar artery divided it equally into two parts. Microscopically it was found to be a small round-celled sarcoma.

Dr. McPhedran had seen the case some months ago. The history was that the child had had a fright, and there was a slight choreic attack followed by paralysis affecting the left side. The child did not speak distinctly, and there was a slight squint. The general appearance was that of diphtheritic paralysis, but against this there was the presence of the knee-jerk. The diagnosis lay between choreic paralysis, diphtheritic paralysis, and tumor at the base of the brain.

CARD SPECIMEN.

Dr. Nevitt presented a ligature removed from the scrotum after lying in the tissues twelve months.

Correspondence.

Editor of THE CANADIAN PRACTITIONER :

SIR,—Perhaps the graduating class of '80 would like to hear from Dr. W. E. Macklin, who went some six years ago as medical missionary to China. I quote from a letter dated "Nankin, May 31st, 1891":

"I have had over 10,000 visits to my dispensaries this year, but have two good students to help me. We had a big mob here a few days ago; but having had word beforehand, we sent our wives and children to Shanghai. A mob tried to burn the M. E. mission hospital, but Mr. Nicols, one of the M. E. missionaries, bravely kept the mob away by showing a revolver till officials came to quell the riot. All is quiet now, and we seem to be in peace, but there are threats all over the country. Wahn, forty miles from here, had a riot, and the Catholics were burnt out. The M. E. mission had their girls' school in Nankin looted and fired, but the fire was extinguished.

"I am married to a sweet little American girl, and we have one boy. We enjoy life immensely, but our home is broken up now by the rioting. I hope I may return to America next year, but am not sure."

Macklin was a Toronto School boy, practised at Coldstream, near London, after graduating, then went to Japan, and finally China.

FRED. H. S. AMES.

SARNIA, ONT., July 20th, 1891.

Reviews.

A Practical Treatise on Fractures and Dislocations. By Frank Hastings Hamilton, A.B., A.M., M.D., LL.D., late Professor of Surgery in Bellevue Hospital Medical College, and Surgeon to Bellevue Hospital, New York, etc. Eighth edition revised and edited by Stephen Smith, A.M., M.D., Professor of Clinical Surgery in the University of the City of New York, etc. Illustrated with five hundred and seven wood cuts. Philadelphia: Lea Brothers & Co., 1891.

This valuable work has now reached its eighth edition. It is, we consider, the most useful book for reference of those written on the special subject of fractures and dislocations. It would be difficult to conceive of anything more complete presented in so concise a form. We have in it faithfully detailed the special features presented to us in the different forms of injury met with in this department of surgical practice. The various methods of treatment which have been found of service are narrated, and their merits fairly discussed with due reference to the principles involved. The value of the work is enhanced by the rich amount of clinical experience which is recorded. The calm and clear judgment of its well-known author commands respect for his expressed opinions, and the well-earned popularity of the work will undoubtedly be maintained in the new edition, which has been ably edited by Dr. Stephen Smith. The book contains 841 pages and is profusely illustrated.

A Treatise on the Diseases of the Nervous System. By William A. Hammond, M.D., Surgeon-General United States Army (retired list), late Professor of Diseases of the Mind and Nervous System in the College of Physicians and Surgeons of New York, etc., with the collaboration of Græme M. Hammond, M.D., Professor of Diseases of the Mind and Nervous System in the New York Post-Graduate Medical School and Hospital, etc. Ninth edition, with corrections and additions. New York: D. Appleton & Co., 1891.

Dr. Hammond's treatise on the diseases of the nervous system is a work which has been long familiar to the profession and has attained a great reputation among the standard books for reference. In the preparation of the present edition, the author has been aided by his son-

A vast amount of clinical material is made use of, and the results of experimental investigation recorded. The book is written in a clear and pleasing style, and obscure conditions are dealt with in a manner which will prove of great assistance in the study of this most interesting class of diseases.

Surgical Bacteriology. By N. Senn, M.D., Ph.D., Professor of Surgery in the Rush Medical College, Chicago, and in the Chicago Polyclinic, etc. Second edition, thoroughly revised. Philadelphia: Lea Brothers & Co., 1891.

Dr. Senn has traversed a vast amount of literature in the preparation of this work. We have recorded in a concise form many of the more important experiments and the results attained by bacteriologists who have done so much to advance the study of this subject. The important bearing which the work of these scientists has on surgical practice cannot be over-estimated, and we therefore welcome a work like Dr. Senn's, for in it we find the practical application of the knowledge we now possess of the life history of micro-organisms to the study of surgical affections. The book contains 259 pages and is well illustrated.

International Clinics. A quarterly collection of clinical lectures on Medicine, Surgery, Gynæcology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otolaryngology. By professors and lecturers in the leading medical colleges of the United States, Great Britain, and Canada. Edited by John M. Keating, M.D., and J. P. Crozer Griffith, M.D., Philadelphia; and J. Mitchell Bruce, M.D., F.R.C.P., David W. Finlay, M.D., F.R.C.P., London. Illustrated. Sold by subscription only. Price per volume: Cloth, \$3.25; half leather, \$3.75. Canadian Subscription and Publishing Co., 821 Craig St., Montreal, Quebec, general agents for Dominion of Canada. Philadelphia: J. B. Lippincott Company, publishers.

The publishers of this work were fortunate in their choice of editors, whose names will at once inspire confidence both in Great Britain and this continent. They have endeavored to obtain the active co-operation of the best clinical teachers in both countries, and have received favorable responses from well-known men in all the principal centres of medical education. The lists in the various departments are so long that we have not space for even a fair proportion of

them. We think we can safely say that they could not be improved.

We cannot conceive of any sort of medical literature which could be more interesting and more beneficial to general practitioners than this. We have received the first volume, and find it is quite up to what the publishers' announcement would lead us to expect. The lectures are of the highest order, being sufficiently scientific, while they are eminently practical. We cannot properly review such a work, but we can indicate our opinion as to its worth. We have endeavored to do that in this brief notice, and hope our readers will understand that we give it our most hearty endorsement and our most cordial recommendation.

Materia Medica and Therapeutics, with special reference to the clinical application of drugs. By John V. Shoemaker, A.M., M.D., Prof. of Materia Medica, Pharmacology, and Therapeutics, in the Medico-Chirurgical College of Philadelphia. F. A. Davis: Philadelphia and London.

Volume II. of this work, which now appears, is an independent volume on drugs. One cannot but be impressed with the number of drugs treated of. Scarcely any drug, now or ever used in medicine, is overlooked; many of them might well have been. Another unusual feature of the book is the number of prescriptions given with the description of the drug. This may be of value to imperfectly educated and lazy men, and no doubt enhances the selling qualities of the book; but it certainly seems out of place in a work so pretentious as this.

Pamphlets and Reprints.

Cancer of the Cervix Uteri in the Negress; with Pyophysometra. By Howard A. Kelly, M.D., Professor of Gynæcology in the Johns Hopkins University.

The Steps of the Cæsarean Section; the Do's and the Don'ts. By Howard A. Kelly, M.D.

OXFORD UNIVERSITY has voted £7,000 to equip the department in human anatomy. At Harvard a similar proposition was voted down. Instruction in anatomy is now being recognized as essential to every University science course.

Obituary.

DR. RICHARD L. MACDONNELL.—The medical profession of Montreal has suffered a great loss in the death of Dr. Macdonnell, at the early age of 38. It was the pleasure and privilege of the writer of this notice to have had an intimate acquaintance with the deceased for many years, and he long ago reached the conclusion that in "Dick" Macdonnell there existed a combination of those rare and good qualities which make the noblest specimen of a man that this country or any other country can produce.

He was educated in McGill University, where he graduated in arts and medicine. In 1876, after the receipt of his M.D., he went to London, where he remained a year and passed for M.R.C.S. Eng. On his return to Montreal he took a position on the teaching staff of McGill. He possessed to an unusual extent the instincts of a teacher, and distinguished himself in that capacity in more than one department. He probably attained his highest distinction in clinical work, and his appointment to the position of professor of clinical medicine in 1889 was highly appreciated by himself, and gave great satisfaction to both faculty and students in McGill. As a practitioner, he confined himself entirely to medicine.

Before he obtained a practice, his father, well known in former days as one of Montreal's ablest physicians, was killed by an accident. None but his intimate friends knew the difficulties that were thrown in his way for a few years. This is the period when his noblest qualities were most apparent. He fought his difficulties with indomitable perseverance and conquered them. The clouds which had hovered round him so long were uplifted. The world was now at his feet. He was recognized as a successful teacher and practitioner. He was happily married to an estimable woman. He was a tall, handsome man, with apparently a grand physique. Truly fortune was covering him with her favors and his prospects were exceedingly bright. Suddenly there came the news that he had had a serious hæmoptysis, and, worse still, a short time brought recurrences. A trip to England and a winter in the south of France caused an improvement, and gave himself and friends much encouragement. He returned to

his work and all seemed well for a couple of years. In June he appeared to get out of sorts, but there appeared no special cause for alarm. He gradually grew worse, however, and was confined to his bed only one short week before he passed through the dark valley.

DR. THOMAS ANDERSON RODGER.—The death of Dr. Rodger followed soon after that of Dr. Macdonnell, and the two events within so short a time will prove a great blow to the many friends of the two physicians. Dr. Rodger was a Scotchman by birth, but had lived in Montreal from the year 1857, when he came to Canada. He took his medical course in McGill, where he graduated in 1869. He immediately commenced practice at Point St. Charles, where he remained until 1884, when he moved to the western part of Montreal.

He was successful in all his undertakings and was exceedingly popular with both the profession and the general public. In 1883 he was appointed chief surgeon to the Grand Trunk Railway. The various surgeons throughout the country who had any business with him in that capacity will have good reason to regret his death. His great tact, kindness of heart, and sound judgment, contributed towards his signal success. No man in Canada had more warm friends than Dr. Rodger, and one and all of these, from the Atlantic to the Pacific, will receive the news of his death with deep regret and profound sorrow. In May last he had an attack of erysipelas associated with septicæmia, from which, we understand, he never fully recovered. We believe, however, the immediate cause of his death, which took place August 6th, at the age of 44 years, was pneumonia.

Therapeutic Notes.

SALICYLATE OF SODA IN CANCER.—Dr. Mollère, a French physician, maintains that the internal administration of five or six grammes of salicylate of soda will relieve the pain of cancer in the womb, even after morphine has been given without effect. It is probable that smaller doses methodically administered would prove equally efficacious.—*The Monthly Magazine of Pharmacy, etc.*

GRINDELIA CIGARETTES IN ASTHMA.—The American physicians have called attention to the value of *Grindelia robusta* in asthma. It has been recommended for this purpose to make use of cigarettes made with tobacco which has been impregnated with the fluid extract of the plant in question; these are said to be efficacious in allaying the paroxysms of spasmodic asthma.—*The Monthly Mag. of Pharmacy, etc.*

GARGLE FOR THE RELIEF OF FŒTID BREATH.—*The Revue Générale de Clinique et de Thérapeutique* gives the following prescription for the relief of this condition:—

R. Saccharine
Salicylic acid
Bicarbonate of sodium } of each, 15 grs.
Alcohol 1 ounce.
Essence of peppermint . . 10 drops.

A teaspoonful of this is to be placed in a wineglassful of hot water, and used as a gargle, once or twice daily.—*News.*

PRURITUS VULVÆ:—

R. Sodium hyposulphite 5 3½
Carbolic acid gr. 30
Glycerine 5 2
Water 5 3½

Sig. To be applied locally.—*Buffalo Medical and Surgical Journal.*

Miscellaneous.

THE weekly issue of the *British Medical Journal* is now 17,000.

PROFESSOR RUBNER, of Marburg, succeeds Professor Koch as director of the Hygienic Institute. He is only 37 years old.

THE Congress of American Physicians and Surgeons will be held at Washington, Sept. 22nd to 25th inclusivé.

GROWTH OF PLACENTA AFTER DEATH OF FŒTUS.—At a recent meeting of the British Gynæcological Society, Mr. Lawson Tait showed an example of ruptured tubal pregnancy in which he found, on operating, a foetus eight weeks old, long since dead, and a great mass of placenta, which had evidently gone on growing long after the death of the foetus.