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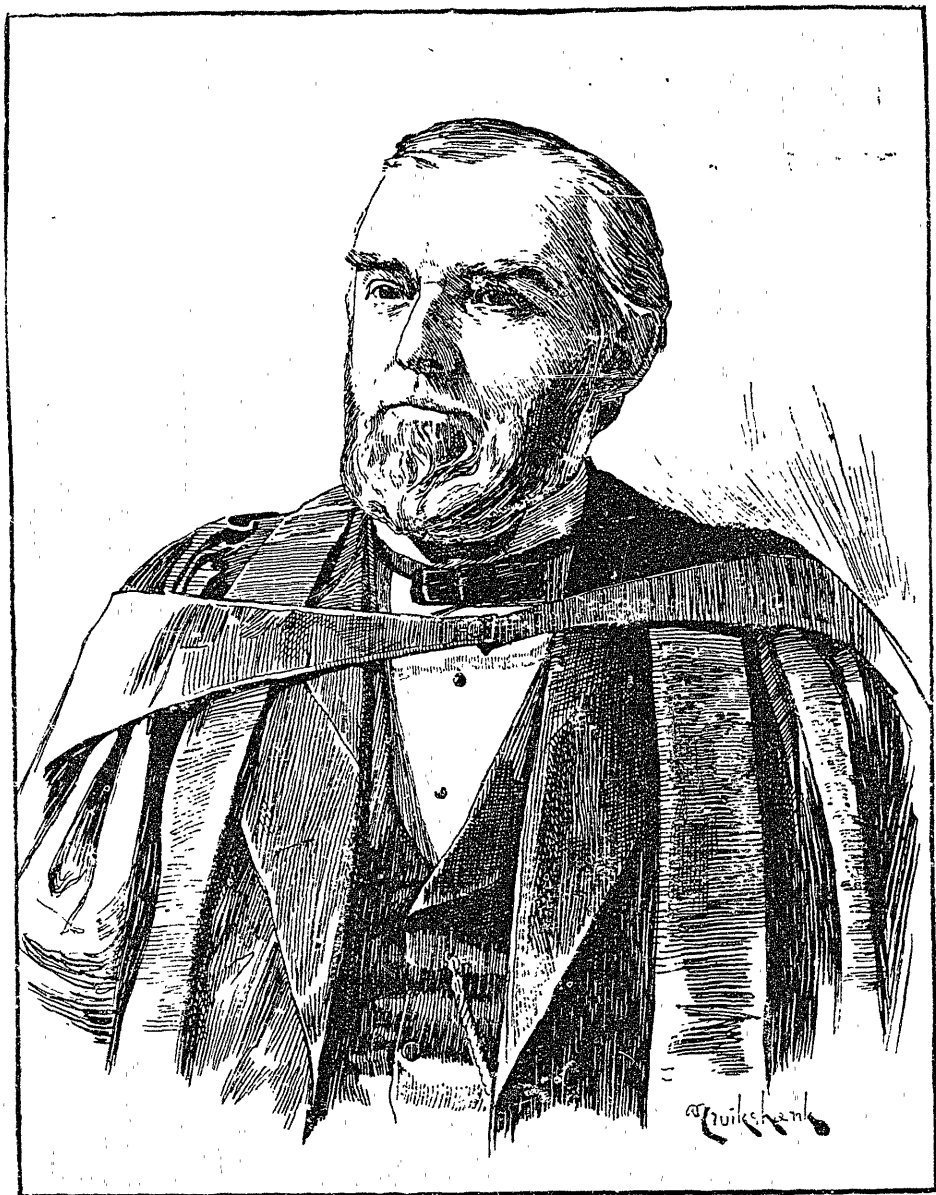
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SUPRA-PUBIC LITHOTOMY.\*

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Supra-pubic lithotomy is now so frequently performed in preference to other cutting operations for stone, or to lithotripsy, that it has become a subject of no little interest.

This operation has been advocated by different surgeons, from time to time, since the middle of the sixteenth century when Franco first performed it. Accounts of the operation have been presented to the profession at intervals of from thirty to a hundred years, usually styled a "new" procedure, and not unfrequently the name of the operator has been attached to the operation, *e.g.*, the "lithotomia Douglasina," described in 1820 by John Douglas, of the Westminster Hospital, London. This history of an operation is not peculiar to supra-pubic lithotomy; old operations which were abandoned as impracticable in the past are re-introduced by the modern surgeon, advocated strongly and practised extensively. The reason for this is that an operation which formerly was difficult and dangerous can now be performed whilst the patient is under the influence of an anæsthetic, and the surgeon is able to proceed with much greater ease, accuracy and safety; still more noteworthy is the fact that the modern

method of antiseptic or aseptic surgery has completely altered the standpoint from which we judge of this or that operation.

The two chief sources of danger in opening the bladder above the pubes are infiltration of urine and wound of the peritoneum. The dangers are very much lessened in the modern method. Franco in 1551 advised the stone to be pushed forward, with the finger in the rectum. Blunt hooks and a special gorget were used for holding the bladder up after being opened. There was never any attempt made to close the vesical wound; charpie or unravelled linen was passed from the external surface to the bottom of the bladder, and the dressings removed three or more times a day. One can understand that after an operation conducted in that manner, where the cellular tissue about the bladder and its connections with surrounding parts were so extensively disturbed, the danger of infiltration would be great, in fact one would be surprised if it did not occur. The danger of wounding the peritoneum is much minimized by rectal distension, the interval between the symphysis pubis and the peritoneum on the anterior surface of the bladder is thus considerably increased. Further, if the peritoneum were wounded no great harm would be likely to be done provided antiseptic measures were adopted during the operation and after treatment.

The following is the method of performing the operation: The pubes should first be shaved, the surface is then thoroughly disinfected, and strict antiseptic precautions are to

\* Read before the Toronto Medical Society.

be taken throughout the operation. An assistant should then introduce an India rubber bag into the rectum, the bag used by Peterson was pear-shaped, but Sir William MacCormack has recommended in preference an elongated-sausage form, which resembles in shape the distended rectum. At this stage it is best to pass a flexible catheter into the bladder, as catheterism is rendered difficult after the rectum is distended. About twelve ounces of water is now injected into the rectal bag; this not only raises the prevesical fold of peritoneum, but also steadies the bladder during the operation. The bladder must be emptied of urine, washed out and then moderately distended with weak solution of boracic acid and warmed to the proper temperature; the quantity injected may be 6, 8, or 10 ounces, determined by the resistance offered. The method of injecting the bladder recommended by Erichsen is the most convenient and safest: A soft catheter is passed, to which an India rubber tube is attached, with a funnel at the end. Through this the solution of boracic acid is poured into the bladder and withdrawn again by lowering the tube below the table. In this way the bladder must be repeatedly washed out. Finally, by raising the funnel from two to three feet above the body, the bladder may be sufficiently distended if the patient be sufficiently under the anæsthetic. Forcibly injecting a fixed amount into the bladder is not free from danger, and has been known to cause rupture of the viscus. The catheter is now withdrawn and an India rubber band fastened around the penis to prevent escape of the fluid by the urethra. A rounded tumor dull on percussion may now be felt above the pubes. A straight incision is made, commencing three inches above the symphysis pubis, and carried down to the symphysis. Then the linea alba is divided, either on a director or by a direct stroke of the knife. The recti muscles are separated by the handle of the knife or a director. When the fascia transversalis is reached, it is picked up in a forceps and slightly notched, a director is then passed through the opening and it is divided. The wound should now be held widely open by retractors, the fat is to be carefully removed from the anterior surface of the bladder. Sir Henry Thomson recommends a sharp-pointed ivory instrument for the purpose,

the difficulty here apprehended is the presence of several veins, which may be abundant in this region. Sir Wm. MacCormack prefers to divide the fat with a knife, the peritoneum may be protected during the incision by passing the left forefinger into the upper angle of the wound and pressing it up. The veins can be secured without difficulty. If the fat be merely pushed aside, the bladder wall may be insufficiently exposed, the fat may also be bruised, and thus becomes more prone to septic influences and to infiltration. When the bladder surface is exposed it is readily recognized by the arrangement of its muscular fibres. Two silk sutures are passed, through the muscular coat only, at the upper portion of the exposed surface of the bladder, a scalpel is then plunged into the bladder, cutting from between the sutures downwards towards the pubes, making the incision of sufficient length to permit of extraction of the calculus without force and if possible without bruising the edges of the bladder wound. When the opening is made, fluid escapes and the bladder collapses, but the two sutures which have been passed are used to prevent its falling into the pelvis, and to keep the edges of the opening apart so that the forefinger may be passed into the bladder. During these manipulations great care must be exercised to avoid disturbing the cellular tissue between the bladder and the pubes. If this be injured, the danger of infiltration subsequently is greatly increased, or suppuration may result. The prevesical fold of peritoneum may present at the upper angle of the wound when the bladder collapses, and were care not taken it might be injured. The calculus should now be extracted by means of short lithotomy forceps, or with a lithotomy scoop and a finger. The forefinger should now be passed into the bladder in order to explore the interior and see if any other calculi be present. Any bleeding points in the edges of the bladder wound must be secured, and then the cavity is washed out with a 3 per cent. solution of boracic acid. A question of great importance is now to be decided, and that is with regard to the treatment of the incision into the bladder. It has been advised that in young persons, those in whom the urine is healthy, and the bladder wall also healthy, an attempt should be made to secure

immediate union. This will be best done by inserting sutures of fine carbolized silk through the muscular coats, not penetrating the mucous lining, after Lembert's method. These stitches must be numerous and sufficiently near each other to keep the wound thoroughly closed when the bladder is distended. A careful trial by moderate distension must be made at this stage, to see if any leakage occur: if necessary additional sutures must be put in. Sir Henry Thompson sees no advantage in attempting to close the opening in the bladder at the time of the operation, desiring rather its patency as a guarantee for the safe and free outflow of urine and other discharges. He further thinks that there is some risk of forcing the urine into the recently divided tissues, as the presence of a catheter in the urethra cannot with certainty be relied on to keep the bladder empty. He, however acknowledges that in children there is little or no risk of extravasation, and the attempt to close the bladder may be more safely made. A point of importance in deciding the question is with regard to the condition of the edges of the bladder wound; if there has been any bruising or tearing of the edges in extracting a large calculus, the attempt to close by suture should not be made, as it will undoubtedly fail. The indications for treatment of the bladder wound, therefore, are as follows: If the urine is healthy and the bladder wall healthy, sutures should be employed and the wound closed, provided that the edges of the incision have not been injured in our previous manipulations. It is usual to find the conditions favorable for suturing in children. If the bladder wound has been closed, a short drainage tube should be inserted in the external wound and the edges brought together by suture. An antiseptic dressing must be applied, leaving an opening for the penis.

Another question in dispute is concerning the use of a catheter. It is common practice in the adult to retain a permanent catheter in the bladder for a week or ten days. MacCormac thinks that the importance of this is overestimated, and Thompson says it cannot be relied upon to keep the bladder empty. It does not appear necessary if the suturing has been done thoroughly. In children it is often absolutely impossible to retain it. The presence of the

catheter causes them to strain in their efforts to eject it, and this may do harm. The urine will probably be passed by the urethra without any difficulty, or all danger may be guarded against by the use of the catheter at short intervals.

If the bladder wound has not been sutured, then a large flexible tube with one lateral opening at the inner end should be left in the bladder for twenty-four or thirty-six hours to aid in maintaining a free aperture; and the patient should lie on his side to facilitate the outflow. The patient should be changed from side to side about every six hours. Some light, loose antiseptic dressing, such as a pad of iodoform wool, is all that is needed for the wound.

The operation is by no means a difficult one, and the dangers are few.

1. Hæmorrhage. There are no vessels of any importance in the line of our incision. There is at times bleeding from the veins in front of the bladder, but if these are cut they can as a rule be secured without difficulty.

2. Rupturing the bladder or rectum if too forcibly distended. This never occurs if the injection is cautiously done.

- 3 and 4. The other dangers are extravasation of urine and wound of the peritoneum. We shall consider these last mentioned dangers more in detail.

Extravasation of urine: This is the most serious and fatal accident after this operation. It is best prevented by exercising great care in preventing any interference with the cellular tissue about the bladder. If this is injured, then extravasation is much more likely to occur; if this is uninjured, then extravasation is impossible. As an additional safeguard, good drainage of the wound should be provided for. Thompson remarks that the risk of extravasation is exceedingly small, because it can only happen as the result of unnecessary and unwarrantable interference with the tissues outside the bladder. "There ought," he says, "to be no action in that region whatever; and how there should be, if the rules of procedure are followed, it is difficult to comprehend. There should be no employment of the finger and no approach of any instrument to any part outside the bladder, except in the line of incision." In the old method of operating, a staff was introduced by the urethra and the point made to present in

the wound; the bladder was then opened by cutting down upon the point of the staff; then the fluid contents flowed out, the bladder collapsed about the protruded staff, and one can easily understand how, under such conditions, tissues about the neck of the bladder would be much disturbed. Subsequent attempts to explore the cavity with the finger or to extract the calculus while the bladder was lying collapsed down in the pelvis, would still further cause injurious interference with the cellular connections.

In the modern method of operating, the bladder is prevented from falling back into the pelvis by distension of the rectum, and if the operator wishes to cut on to the point of a staff, he fixes the bladder wall by passing loops of silk through the muscular coat, or lays hold of it by a hook or forceps. The staff is never necessary in the male, but in the female it may be required.

Wound of the peritoneum. Dulles has presented a table of statistics of 478 cases, which were reported from the days of Franco to the year 1875. He mentions 13 cases of injury to the peritoneum in his 478 collected cases. Dr. Garson (*Edinburgh Medical Journal*, Oct., 1878) undertook expensive investigations as to the effect of the distension of the rectum and the bladder. The following was the course pursued: The rectum of a well-developed middle-aged man was emptied by injecting water; then a collapsed India rubber bag of oval form and

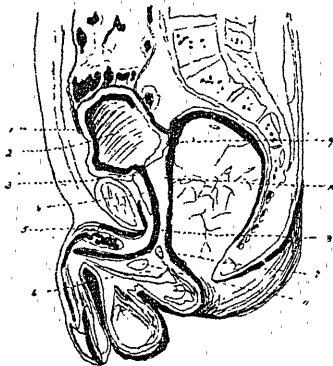


Fig. 1.

with a tube attached to one end was introduced. The bag was distended with ten ounces of water. A soft catheter was then passed into the bladder and eight ounces of water injected. The body was then laid in a dry zinc trough,

outside of which was a freezing mixture of salt and ice. After it was frozen, which took about sixty hours, it was sawn through as nearly as possible in the middle line. The preparation was then cleaned of saw dust and washed in

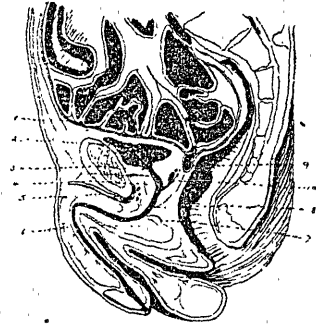


Fig. 2.

ice cold water, and afterwards placed in absolute alcohol, still in a frozen condition. There it was kept until perfectly hardened, without any perceptible displacement of parts taking place during the process. Fig. 1 (taken from Garson's paper) is an exact representation of the section. The bladder is entirely raised up out of the pelvic cavity, and along with it the peritoneum also, both in front and behind, so that the bladder is found to be in the same position as in the new-born child.

Another experiment of Garson's was carried out as follows; In the body of a middle-aged man ten ounces of water was injected into the rectal bag and six ounces of water in the bladder. An incision, 7 C.M. ( $2\frac{1}{2}$  inches) long, was made down to the bladder above the pubes; the peritoneum was entirely above incision. In order to ascertain the exact distance of peritoneum above pubes, an incision into peritoneal cavity was made at umbilicus, and the finger inserted; the fold of peritoneum was then discovered to be 6 C.M. (2 2-5 inches) above pubes. He next emptied the rectal bag, and the bladder was observed to sink down directly into the pelvis, carrying with it the peritoneum, and when the rectum was quite empty the fold of peritoneum was only 2.5 C.M. (1 inch) above the symphysis.

He showed by another experiment that distension of the rectum alone would raise the bladder (even if the latter be quite empty), and with it the fold of peritoneum. Dr. Garson gives in his paper (Fig. 2) a wood-cut of a frozen section,

made after the same manner by Prof. Branné, where the parts are in their normal condition, the rectum is filled (naturally) and not distended. This diagram shows the relation of the peritoneum to the bladder when the viscus

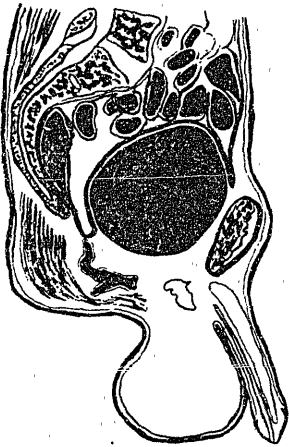


Fig. 3.

is collapsed. These investigations of Garson prove that rectal distension will raise the prevesical fold of peritoneum very considerably above the pubes.

It has been stated by some that distension of the bladder alone is sufficient, and that scarcely half an inch more can be gained by distending also the rectum. The question was decided by the investigations of Fehleisen in 1884, he completely verified Garson's original experiments. He, too, experimented with frozen sections. The diagrams I show you have been reproduced from his plates.

In Fig. 3, the rectum is quite empty; the bladder contains  $10\frac{1}{2}$  ounces of fluid; it is rounded. The fundus is almost horizontal, the lowest point of Douglas' pouch is about the same level, while the prevesical fold of peritoneum is only half a centimetre (1.5 inch) above the superior border of the pubes.

In Fig. 4, the bladder contains 7 ounces of fluid, and the rectum about  $16\frac{1}{2}$  ounces, injected into a cylindrical tampon. The bladder has lost its rounded form and is somewhat pentagonal. The bladder is close behind the abdominal wall, and the anterior fold of peritoneum is 4 centimetres (1.5 inches) above the border of the pubes.

Another experiment was made in which the bladder was largely distended,  $22\frac{1}{2}$  ounces

being injected, as much fluid as was contained in the previous case in the bladder and rectum together. The bladder became spherical, and the anterior peritoneal reflection only 2 centimetres (4.5 inch) above pubes. This shows that if the bladder only be injected it will distend backwards rather than upwards.

The question has therefore been proved most conclusively that distension of the rectum with moderate distention of the bladder does away with the danger of wounding the peritoneum.

In 1880, Prof. Petersen, of Kiel, advocated the supra-pubic route to the bladder, on grounds derived from the investigations of Garson. Petersen used a pear-shaped India rubber bag with a capacity of about sixteen ounces, for introduction into the rectum.

It has already been stated that caution should be exercised in distending the rectum and bladder in the living subject. A case came to the knowledge of Mr. Cadge in which fifteen ounces injected into a rectal bag caused a tear of the mucous membrane. In children, three to four ounces is usually sufficient.

The treatment at present advocated for the general run of cases of calculus in the bladder is lithotripsy. This operation, when practised by men of experience, has yielded excellent results. When the stone is large, however, bet-

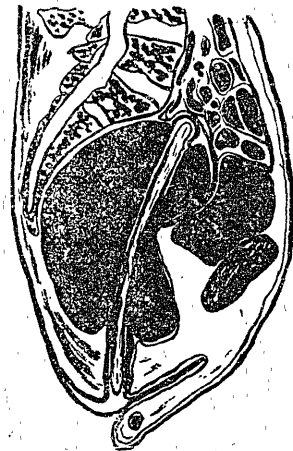


Fig. 4.

ter results are obtained by lithotomy. Formerly the operation performed in those cases of large calculi was lateral lithotomy, but the high operation is now preferred. Let me quote Sir Henry Thompson's words, used by him in a discussion

before the British Medical Association in October, 1886. He says: "I shall venture to maintain here that supra-pubic is decidedly superior to the lateral for the removal of stones which are much above the average size, and I do so on the following grounds:

"1. Because in the supra-pubic operation there are no important structures lying in the line of the incision or sufficiently near to be rendered liable to injury either by the knife or by the forceps.

"2. Because the space for removing a large stone above the pubes is practically unlimited.

"3. Because there is little or no danger to be apprehended from hemorrhage, and if it does occur, which rarely happens, it may be readily dealt with.

"4. Because the incisions are certainly more easy to perform than those of lateral lithotomy, while the removal of a large stone, always the most difficult and dangerous part of any operation on the perineum, is safe and easy by the supra-pubic route.

"5. Because, during the after treatment, the urine leaves the supra-pubic wound more directly, and therefore more safely, than it does by the long and lacerated opening which forms the communication between the bladder and the perineal surface after the lateral operation for a large stone.

"6. Because antiseptic dressings can be employed in the former operation and cannot be made available in the latter.

"Lastly, because in the supra-pubic operation it is impossible to cut the rectum, to inflict any injury on the sexual organs, or to make a urethro-rectal or perineal fistula, any or all of which are liable to follow the lateral operation in a patient with a large stone."

These statements ought to bear weight, coming from a surgeon of such extensive experience. Lithotripsy is an operation which depends for its success to a large extent on the skill and experience of the operator. It is probable that in many cases in which Sir Henry Thompson, or a man of equal experience, would perform lithotripsy, it would be better for the great majority of surgeons to do supra-pubic lithotomy. The results obtained would, in all probability, be better. One very important fact to take into consideration is that recurrence after lithoto-

my is very rare; only 40 out of 1030 individuals were operated on a second time. In Sir Henry Thompson's cases of lithotripsy there was a recurrence of about 13 per cent. This constitutes a serious drawback to the operation.

Hitherto the mortality in supra-pubic lithotomy has been higher than in the lateral operation, but we must take into account the fact that the high operation has formerly been done chiefly in cases of unusual difficulty. The operation has been restricted to very large calculi, or perhaps been performed after the lateral operation has been attempted and failed, perhaps on the same day or the day following. Thompson publishes twenty-five cases of large calculus weighing more than  $2\frac{1}{2}$  ounces, removed by the lateral, medio-lateral, and bi-lateral operation. There were seventeen recoveries and eight deaths. Eleven cases of large calculus and tumor removed by supra-pubic operation, with one death only; seven cases of very large calculus removed by lithotripsy, chiefly at one sitting: no death. He tells us that the mortality in lateral lithotomy is almost in direct ratio to the size of the stone.

One may conclude, then, that lateral lithotomy, which has been such a favorite operation in the past, and so successfully performed, will be replaced more and more by the supra-pubic method. There are undoubtedly cases still in which the lateral operation will commend itself to the surgeon; such cases, for instance, in which there is stinking urine and advanced vesical catarrh. Here we not only wish to remove the stone, but we wish to drain the bladder, and this can be more effectually done through the perineum.

The operation has been repeatedly performed on children, and with marked success. From time to time cases are reported in the journals, and the results are, as a rule, eminently satisfactory. Mr. Stanley Boyd operated on a boy in the Paddington Green children's hospital in May, 1887, where I had an opportunity as house-surgeon of watching the subsequent progress of the case. The boy was five years of age. A calculus was detected by sounding. The urine was acid, contained a trace of albumen, phosphates and blood; no pus. Supra-pubic lithotomy was performed after the method described in a preceding part of this paper. There



was no difficulty in opening the bladder and extracting the stone, which was a short spindle-shape, and weighed 15 grains. The wound in the bladder was scarcely more than half an inch. Seven catgut sutures were passed through the muscular coat, and no leakage occurred on gentle distension of the bladder. The recti were brought together by five short catgut sutures through their sheaths, a track being left for a small drain-tube down to the bladder wound just above the pubes. The edges of the skin incision were brought close together, iodoform was dusted on, and an antiseptic dressing applied. A catheter coude was tied in the bladder. The urine drained away freely. The patient did well. On the fifth day the catheter was removed. Fourteen days after the operation the wound was entirely healed, and five days subsequently he was discharged from the hospital.

The operation is so simple compared with the much more severe procedure of lateral lithotomy in children. There is no denying the fact, as far as the operation itself goes, that lateral lithotomy in boys has been one of the most successful operations in surgery, but it is very often very difficult to perform. The bladder in childhood is an abdominal rather than a pelvic organ, as has been more particularly demonstrated by the frozen sections of Symington, and great difficulty is experienced in reaching the cavity. The tissues, too, are so delicate that there is no small danger of lacerating the parts extensively, and perhaps causing entire separation of the bladder from the urethra whilst groping about with the finger in efforts to reach the cavity. The surgeon has even introduced his finger into a distinct cavity, which he believed to be the bladder, but which proved to be the recto-vesical space. Further, the prostate is only a rudimentary organ in childhood, and there must necessarily be some cutting of the neck of the bladder, causing, perhaps, injury to the vesiculae seminales, and sterility may be the consequence. The difficulty in adults is finding the stone, whereas the difficulty in children is that of reaching the bladder.

The operation of supra-pubic lithotomy in boys is, therefore, to be recommended, because of its simplicity and because it does away with the chief risks of lithotomy in children.

Figs. 1 and 2 are those taken from the *Edin. Med. Jour.* in Garson's paper. Figs. 3 and 4 are from my own drawings.

196 SIMCOE STREET.

## Selections.

**LANOLIN-SUBLIMATE.**—Although most antiseptics lose their germical properties when dissolved in oil or alcohol, sublimate-lanolin, according to Gottstein, acts as powerfully disinfectant as a watery solution of sublimate. A salve is prepared by adding to a fixed quantity of lanolin, freed from water, a given weight of 1 to 1,000 or 1 to 5,000 sublimate solution. The antiseptic value of this mixture was attested by numerous experiments on animals.—*Therapeutische Monatshefte.* — *International Journal of Surgery.*

**VENTILATION OF DWELLING-HOUSES.**—A paper, dealing with the subject of the ventilation of dwelling-houses, was read before the Edinburgh Association of Sciences and Arts by Mr. Robert Watson, in which a strong plea was urged for the supply of hot air to houses. According to a system which he demonstrated, the air was warmed in a chamber as it entered the house, and was admitted by means of a long grating into the entrance hall, so that the hall and staircase became a kind of reservoir of heated air for the supply of the house. The method was both economical and equal.—*Brit. Med. Journal.*

**NEW FORMS OF NARCOTISM.**—Amongst the existing plagues of civilization must now be added some new forms of intoxication, showing how readily the latest additions to the means of relieving human suffering are seized upon as means of self-indulgence, however dangerous. Cocainism is already a recognized form of self-intoxication, leading to special kinds of hallucinations and insanity. MM. Magnan and Saury report three cases of hallucination due to the cocaine habit. One patient was always scraping his tongue, and thought he was extracting from it little black worms; another made his skin raw in the endeavor to draw out cholera microbes; and a third, a physician, is perpetually looking for cocaine crystals under his skin.

Two patients suffered from epileptic attacks, and a third from cramps. It is important to notice that two of these patients were persons who had resorted to cocaine in the hope of being able to cure themselves thereby of the morphine habit, an expectation which had been disappointed. For more than a year they had daily injected from one to two grammes of cocaine under the skin, without, however, giving up the morphine injections, which were only reduced in quantity. The possibility of substituting cocainism in the endeavor to cure morphinomania is a danger, therefore, which must be carefully held in view.—*Brit. Med. Jour.*

TREATMENT OF ERYSIPELAS.—By Dr. C. Lauenstein. The author has successfully used the method of Kraske-Riedel in five cases of severe erysipelas of the head and neck. The treatment consisted in surrounding the erysipelatous area with a broad zone of numerous fine incisions, from six to eight centimetres in length and crossing each other. The parts are first thoroughly disinfected, and after incision as much as possible of the serous infiltration is removed by pressure, and a wet dressing of corrosive sublimate, 1 to 1,000, applied, which is changed once or twice daily. Under this treatment the erysipelatous redness and the constitutional symptoms disappear rapidly, and it is seldom necessary to repeat the incisions.—*Deutsche Medicinische Wochenschrift*.—*International Journal of Surgery.*

THE PREVENTION OF CONCEPTION.—At the Third General Meeting of Russian Medical Men at St. Petersburg, Dr. Petr N. Seidler read an interesting paper on the truly burning question of the prevention of conception. While condemning an indiscriminate employment of any preventative means, the author believes that the practitioner is fully justified in interfering with conception in the following three categories of cases: 1. In women suffering with a more or less advanced pulmonary phthisis. 2. In women with organic cardiac disease. 3. In women suffering from profound anæmia, or failure of the general systemic nutrition with a hereditary tendency to pulmonary tuberculosis. During a discussion following Dr. Seidler's communication, Dr. Nil I. Voblyi suggested that

prevention is indicated, further, in such women as have passed through extra-uterine pregnancy.—*Medical and Surgical Reporter.*

MANUAL CONVERSION OF FACE AND OCCIPITO-POSTERIOR INTO OCCIPITO-ANTERIOR POSITIONS.—Loviot (*Nouv. Arch. d'Obstet. et de Gyn.*) advocates the manual conversion of face into vertex presentation in difficult face cases. He ruptures the membranes and hooks down the occiput by means of the hand in the uterus, under chloroform. Rapid delivery is then effected by the forceps.

Troublesome cases of occipito-posterior position are likewise treated by manual interference. With the hand in the vagina, the four fingers are placed behind the occipital pole, the thumb against the anterior temple: the occiput is thus rotated to the front during a pain. Application of the forceps before releasing the head from the grasp of the hand is sometimes necessary to prevent recurrence of the mal-position. It goes without saying that asepsis is a *sine qua non* in these procedures, and makes scientific practice of what in preantiseptic days would have been termed meddlesome.—*Brooklyn Med. Jour.*

AN EXORBITANT FEE (Fact).—A correspondent writes:—A woman brought her daughter to a friend of mine practising in the "Pottery" district. The girl had dislocated her jaw, which dislocation was soon reduced by the usual method, and a bandage applied to keep it in position. On being asked the fee, my friend, not having had a similar case in private practice, went into another room and consulted a tariff of medical charges published by the Shropshire Ethical Society, and found "for reducing dislocation of jaw, 1 to 3 guineas." Seeing the woman was not in good circumstances he felt that the minimum fee was not likely to be forthcoming, so he tentatively asked whether the girl had ever had the jaw out before. "Oh, yes, sir," she replied, "about twelve months ago, and was treated by a doctor at ———." "How much did he charge you?" "A shilling, sir?" "Didn't that strike you as being a somewhat peculiar fee?" "Well, sir," was the reply, "we did think it a good deal."—*Birmingham Med. Review.*

THE  
Canadian Practitioner

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

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

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TORONTO, JUNE 17, 1889.

FOUR YEARS' COURSE — TORONTO  
AND MCGILL.

In our issue of May 16 an article appeared on the "Length of the Course of Medical Studies," in which appeared the following words: "For many years—too many by far—the University of Toronto stood alone in its rigid adherence to the rule requiring from students an attendance at lectures for four full sessions before admitting to its final examination." Our attention has been called to the fact that McGill University of Montreal has for many years demanded a *bona fide* attendance of four years on lectures. We are well aware of this fact, and it has been ever the aim of this journal to do full justice to McGill Medical College, which, in our opinion, has for a long time stood well to the fore among medical institutions of this continent. We hope it is almost needless to state that our remarks referred to the universities of Ontario, and to them only. Our references to the Ontario Medical Council and the Provincial University will, we hope, show our meaning, but our first sentence, with its reference to medical education in Canada, was likely to mislead. Without any further explanations, we may simply state that we did not allude to McGill University, and have to express our regrets that we were not more careful in our phraseology. McGill has done, and is doing good work for medical education in Canada. At one time she probably stood first among Canadian medical colleges. While we hope her friends will pardon us for stating that we believe that time

is past, still we must express our best wishes for her success, as she certainly has nothing like her equal among her rivals in her own Province.

(Since writing the above, we have received a communication from Dr. Shepherd, which we publish in this issue.)

THE MEETING OF THE ONTARIO  
MEDICAL ASSOCIATION.

The success of the Ontario Medical Association continues to increase from year to year. The recent meeting of June 5th and 6th was very satisfactory in all respects. There was a plentiful supply of excellent papers, there were many interesting discussions, there was every evidence of good fellowship and thorough enjoyment. The general method of conducting the proceedings was all that could be desired. The division into sections was highly approved, and will probably be carried out at all future meetings. To whom shall we give the chief credit for the undoubted success of this, the largest and best meeting that the society has ever held? We can scarcely particularize, when we know that all present worked with such singular unanimity in the interests of the Provincial Association. The officers and various committees worked admirably, and received a hearty support on all hands, which must have been very gratifying. The President and Secretary won golden opinions from all the members. Their labors were not confined to the days of the meeting, they had been persistent during the whole previous year.

The officers and committee-men may work, but their efforts would accomplish little without the generous assistance of the profession in all parts of the Province. The Association belongs to Ontario, not to any city or sectional clique. No one could be present at this meeting without feeling assured of this fact. There were many visitors from the United States—not enough from Montreal. All were welcome. We hope they received a reception which prevented them from feeling like "strangers in a strange land." They certainly contributed much towards the success of the meeting. If Montreal neglected to send many, it gave us two old Ontario boys, Stewart and Buller, who will always receive a

hearty welcome from us when they visit the Province they should never have left.

To the officers for the coming year we offer our congratulations. The election of Dr. Temple as President was evidently satisfactory to all the members. We feel sure he will prove Henderson's equal—we can ask for nothing more. The Vice-Presidents are strong and worthy men, representing various sections, and will render invaluable assistance to the President. The present prospects for the Association are unusually bright. We have not yet arrived at that period in its history when we can afford to rest on our oars. We are still ambitious, and hope that next year's meeting will eclipse all others, not excepting the recent one, which was so eminently successful.

#### PROGRESS OF THE ASSOCIATION.

The following details with reference to the various meetings of the Association will be found interesting. There have been altogether nine annual gatherings from 1881 to 1889 inclusive, held at Toronto, Hamilton and London, with numbers present as follows :

	Number Present.	Place of Meeting.
1881	132	Toronto.
1882	117	"
1883	143	"
1884	88	Hamilton.
1885	127	London.
1886	142	Toronto.
1887	193	"
1888	196	"
1889	217	"

#### NOTES FROM THE MEETING.

The venerable and popular first President of the Association, the veritable Nestor of the profession in Ontario, Dr. Workman, in his first appearance at the meeting met with a reception suitable for a king. May he be spared for more of the same.

It was a graceful and generous act to denote one hundred dollars to the Ontario Medical Library, as proposed by the Hon. Dr. Sullivan and carried unanimously.

From a social point of view the profession of Toronto entertained well. They didn't know so much about this sort of thing a few years ago. We are glad they know now.

The Minister of Education was received in

an enthusiastic manner, and delivered a neat and graceful speech.

The Minister of Education and Mr. Marling were exceedingly kind in their efforts to show every consideration to the Association, and place so many hours at our disposal.

The contest over the heart between the two gladiators elicited applause from both pit and gallery.

The President of the Ontario Medical Council, Dr. Burns, was called to the platform amidst cheers, and gave a nice little speech.

The Hon. Dr. Sullivan was also requested to take a seat on the platform, and gave the Association some taffy in genuine Irish style. Highly appreciated.

On the last night of meeting a genial but well-backboned Irishman showed that he could not be sat upon.

Toronto is likely to be the final resting place for the Association; but, all the same, Toronto would not object to an occasional visit elsewhere.

Dr. Henderson made an excellent presiding officer, and was sound on the Irish question.

Dr. E. E. King's cystoscopic demonstration was an *electrical* feature of the meeting.

The retiring Treasurer richly deserved the cordially unanimous vote of thanks tendered him by the Association.

Where was a good portion of Hamilton? Where was London? Where was Ottawa?

"Happy to meet, sorry to part, happy to meet again."

#### NOTES.

N. Y. POST-GRADUATE MEDICAL SCHOOL.—The summer term of this institution opened on June 17, 1889. The fees for this session are one-half those of the winter term, and yet the advantages in the Dispensary of the school and in many of the hospitals of the city are quite as good as during the winter.

At the spring meeting of the Board of Directors of the New York Post-Graduate Medical School the following additions were made to the Faculty: J. H. Ripley, M.D., Prof. of Diseases of Children; R. W. Taylor, M.D., Prof. of Diseases of the Skin; J. B. Emerson, M.D., Prof. of

Diseases of the Eye and Ear; Frederic Bagoë, Ph.B., Prof. of Pharmacology.

THE following new appointments have been made at the New York Polyclinic: Dr. Thos. R. Pooley, Surgeon in Chief of the New Amsterdam Eye and Ear Hospital, Ophthalmic Surgeon to the Sheltering Arms, Consulting Ophthalmologist to St. Bartholomew's Hospital: Professor of Ophthalmology. Dr. B. Sachs, Consulting Neurologist to the Montifion Home for Chronic Invalids: Professor of Neurology. Dr. L. Emmett Holt, Consulting Physician to the Hospital for Ruptured and Crippled, Visiting Physician to the New York Infant Asylum: Professor of Diseases of Children. Dr. August Seibert, Physician to the Children's Department of the German Dispensary: Professor of Diseases of Children. Dr. H. Marion Sims, Gynecologist to St. Elizabeth's Hospital and New York Infant Asylum: Professor of Gynecology. Dr. Wm. H. Fluhrer, Surgeon to Mt. Sinai and Bellevue Hospitals: Professor of Genito-Urinary Surgery. The Polyclinic has increased its hospital facilities by the purchase of a large building immediately adjoining its original property, and after making necessary changes will furnish and have it open by Sept. 16th, when the regular session will commence.

THE LATE DR. J. B. HUNTER, OF NEW YORK.—At a meeting of the Toronto Medical Society held June 11th, the following resolution was passed: "That this society has learned with the most profound regret of the premature demise in New York, on the 10th inst., of one of its most distinguished honorary members, Dr. James B. Hunter. Regarding Dr. Hunter as a Canadian and a Torontonion, so many of his earlier years having been spent amongst us, his fellow-citizens here have always looked with a profound pride and satisfaction upon the eminent position which by virtue of his great natural ability, unimpeachable integrity and untiring industry he achieved for himself and easily maintained amongst the great names of the medical profession in the American metropolis, and it is therefore with a more than ordinary—even a family—grief that we are called upon to deplore, in common with our colleagues of New York, so great a loss. A gentleman of unbounded cour-

tesy and amiability, a physician of varied experience, wide culture and sound judgment, a surgeon of remarkable skill and dexterity, prudence, scientific sagacity and almost phenomenal success, a faithful and most thoughtful friend, an exemplary son and devoted brother, he leaves behind him, alike in the professional and social spheres, a brilliant example, worthy of all imitation by his survivors, a deep lacuna not easily to be filled by his successors. To his sorrowing relatives, friends and colleagues this society desires to extend its heartfelt sympathy in our common loss, accepting in all reverence and humility the inexorable decree, but at the same time feeling in all its fulness the exclamation of the heathen poet, 'Quis modus aut pudor set desiderio tam carcapitis!' The funeral from his mother's residence in this city was attended by a large number of Toronto's medical men, Dr. Weir, of New York, and Prof. Osler, of Baltimore, were also present.

W. T. AIKINS, M.D., LL.D.

Dr. W. T. Aikins, whose portrait appears in this issue of THE PRACTITIONER, is well known to our readers as one of the ablest surgeons of this continent. He was born in the County of Peel in this Province in 1827. He received his preliminary education in Victoria College, Cobourg, and his medical education in the Toronto School of Medicine and Jefferson Medical College, Philadelphia. He received his license to practice in 1849 and the degree of M.D. from Jefferson in 1850. After leaving Philadelphia he commenced practice in Toronto, and very soon acquired a reputation as a skilful and careful surgeon. He commenced his career as a teacher of anatomy in Rolph's School of Medicine in 1850 and was remarkably successful. He was appointed lecturer and surgeon in the Toronto School of Medicine in 1856 and has taught this subject with marked success until the present time. As a surgeon and a teacher of surgery he is practical in the highest degree, careful in his methods and correct in his judgment.

He in conjunction with his colleague Dr. H. H. Wright and others took an active interest in the formation of the Ontario Medical Council. He has acted as treasurer for this body from the date of its organization to the present time, and

his very careful and able management of its finances has done much towards placing it in its present strong position. He has held many positions as surgeon for organized charities. He was surgeon to the Toronto General Hospital from 1850 till 1880, when he was placed on the consulting staff where he still remains. He was president of the Toronto School of Medicine for many years, and when the Medical Faculty of the University of Toronto was re-established in 1887 he was elected Dean, and still retains that position. He received the Degree of LL.D. from the University of Victoria College in 1881, and the same degree from the University of Toronto at the recent convocation this month. He is now sixty-two years of age, active, healthy and well preserved. He is one of the most careful antisepticians in the world. He has visited the Hospitals of the old world three times—in 1873, 1880 and 1882, and studiously observed the most modern of surgical methods and operations. We beg leave to congratulate him on his distinguished and well deserved success, and hope he may be spared for many years to continue his good work.

## Meeting of Medical Societies.

### ONTARIO MEDICAL ASSOCIATION.\*

TORONTO, Wednesday morning,  
June 5th.

The President, Dr. Henderson, of Kingston, in the chair.

After the reports of several of the committees had been received, Dr. Gibson (Belleville) read the history of a case of

#### SYMMETRICAL GANGRENE,

which he was inclined to consider an example of Raynaud's disease. The gangrene was limited to the toes, the patient eventually losing all the toes of the right foot and the second and third toes of the left foot. The patient was a male, aged 47. The constitutional symptoms were less severe than the local. The onset of the disease was sudden, commencing with pain and a feeling of numbness in both arms and legs, but more especially in the legs; a condition of ischæmia was then observed in the feet; this

was followed by cyanosis, erythema and gangrene, limited to the parts above mentioned. Dr. Gibson concluded his paper by giving a short sketch of the supposed pathology of Raynaud's disease, and also a brief account of its clinical history.

No discussion followed on this paper.

Dr. J. Campbell (Seaforth) read the history of a case of

#### ACUTE MUCO-ENTERITIS,

occurring in a male patient, aged 60. The duration of the illness was protracted, lasting over three weeks, when recovery took place. The treatment mainly consisted in washing out the bowel once or twice daily with a large amount of very weak carbolic solution, along with large doses of bismuth and opium internally. An occasional enema of starch and opium was also administered. Dr. Campbell laid great stress upon the efficacy of the free washing out of the bowel, and also on the necessity of large doses of bismuth.

Dr. McPhedran objected to the use of carbolic acid in the injections, as it is well-known that a very small quantity is readily absorbed from the bowel, giving rise to alarming toxic symptoms.

Dr. Campbell next read notes of a case of

#### LOBULAR PNEUMONIA,

occurring in a primipara at confinement. The case was marked by high temperature and suppression of lacteal secretion, recovery eventually taking place.

#### Afternoon Session.

Dr. Henderson then delivered the presidential address.

#### DISCUSSION ON SURGERY.

In opening this discussion, Dr. W. T. Aikins, of Toronto, chose as his subject

#### THE GENERAL MANAGEMENT OF THE PATIENT AND SICK-ROOM IN SURGICAL CASES.

He emphasized the importance of attention to details that are apt to escape the observance of the surgeon who is not painstaking and methodical in his arrangements. A great deal of attention is paid by sanitarians to the disposal of fæces and the closing of wells in thickly populated parts, while the exhalations from the kidneys, skin and lungs are comparatively neglected, though they are certainly not less important. In directing attention to the

\* We are indebted to Drs. G. A. Peters and W. P. Caven for the report of this meeting.

ventilation of the sick-room, he alluded to the fact that about 2,500 people die annually in this province of consumption, and opined that this number might be reduced by at least 1,000 by proper adjustment of ventilatory apparatus in schools and in sleeping-rooms, where we spend at least one-third of our existence. He believes that a culpable disregard of these precautions has been the means of reducing the physical development and bodily vigor of the present generation of Canadians far below that of their ancestors who came from the old countries. If ventilation has such a baneful influence on those in health, how much more serious would be its effects upon those who have undergone the shock of a severe operation, who are the subjects of exhausting discharges, or who have been debilitated by suffering! Hence the surgeon should not consider the appointments of the room unworthy of his notice. If possible to avoid it, the patient should never be required to inhale air which has previously passed through the lungs either of himself or his attendants. Bear in mind that the air which has been heated in the lungs of the patient ascends. Accordingly provide an escape for it near the top of the room.

In winter, open the window above to the extent of two or three inches, and also raise the lower sash according to the requirements of the room. The door should be shut. The air which enters through the lower openings should be filtered through a couple of layers of mosquito-netting, with a thin layer of cotton batting between them. This netting is tacked to a skeleton sash, which fits the lower opening in the window. The air thus filtered, not only of dust, but of many invisible germs, is directed towards the floor, so that it becomes warmed before it reaches the patient, and never creates a draught.

In summer the windows are opened wider, and larger filters are used. If there is a stove-pipe opening into the chimney, the stopper is removed, and a lamp, to be kept burning constantly, is placed on a shelf a few inches below this opening. A constant current of the impure air of the upper strata of the apartment is thus caused to escape by way of the chimney.

The plans proposed by the speaker were adapted to the homes of the middle and poorer

classes, among whom a large proportion of our patients is found.

The attention of the surgeon was also directed to the teeth of his patients. It is well to make it a routine practice to examine the teeth as well as the tongue, and where the grinders are absent to insist upon the wearing of a plate. In persons predisposed to cancer the habitual ingestion of imperfectly masticated hard food may irritate the stomach to such an extent as to cause a development of the disease.

The discussion was continued by Dr. Ruttan, of Napanee, who had long used a filter similar to that described by Dr. Aikins, but made of wire and filled in with oakum, to which any antiseptic that was thought necessary could be added. He generally trusted to the grate or stove to take out the impure air.

The room in which an operation is to take place should be prepared the day before, by having the wood-work and walls thoroughly scrubbed with a bichloride solution, and placing the sash with the antiseptic filter in the window at least twelve hours before the operation.

In continuing the discussion, Dr. Wm. Britton, of Toronto, recommended that the patient should be surrounded by as cheerful an atmosphere as possible. He related an interesting reminiscence of his own experience when suffering from mumps in boyhood to illustrate the evil effects of sombre surroundings and tearful friends.

He thought there was too great a tendency even in late days to restrict too narrowly the diet of invalids, though the days of water-gruel and other similar aliments (?) were happily past. The mortality in lying-in cases is certainly increased by too great restriction of diet, as is also the liability to milk-leg, septicæmia, erysipelas, etc. He quoted from Sir James Simpson some very convincing statistics, showing the intimate dependence of the mortality after amputations upon the facilities for the supply of fresh air. Hence he advocated the use of small wards in hospitals in preference to large ones, and of the cottage system as being the best way of giving patients an adequate supply of fresh air.

Dr. Skene, Brooklyn, N.Y., considers foul air as infinitely worse than foul water. We must breathe air, but we need not necessarily drink water. In abdominal surgery he always tried to keep the air of the operating room as pure as

possible by limiting the number of the spectators. Many surgeons make elaborate preparations in regard to the instruments, room, bedding, etc., and then allow the air to be contaminated during the operation by the exhalations of numerous onlookers. The method of filtering the air as advocated by Dr. Aikins has been in use for many years in the Children's Hospital in Albany, and with good results. The principle is also carried out in many of the best constituted Houses of Parliament in the world.

Dr. Oldright, Toronto, insisted that the air admitted to the patient should be of a suitable temperature, and in order to that end, recommended that the stove be placed between the patient and the window, and as near the latter as possible. He considered the Smead-Dowd System, by which the foul air is drawn off from the bottom of the room, the best.

Dr. Rowsell Park, Buffalo, then read a paper on

#### THE RADICAL CURE OF HERNIA.

As about twenty per cent. of mankind suffer from hernia, it is not surprising that many operations have been devised with the hope of a permanent cure. The author of the paper gave a brief review of these operations, tracing the gradual evolution of the mode of procedure up to the present. He then described his method of operating, which presented nothing that could be regarded as new or original, but was a combination of several well-known plans. The parts are shaved, washed antiseptically, and an incision made over the external ring. The sac may be found without much search, but is sometimes blended with the cord in such a way as to be very confusing to the surgeon. When the sac is isolated, after splitting up the canal if necessary, it is opened. If omentum is found, it is ligated and removed, the pedicle being dropped. The sac is then ligated with catgut close to the internal ring and divided close to the ligature. If the hernia be a congenital one, it is similarly ligated close to the testicle, so as to leave a tunica vaginalis. A similar procedure is adopted in femoral hernia. The pillars of the ring are then drawn close by silver wire, which is twisted, cut short, and the ends turned over upon themselves. The integumentary wound is closed with catgut, generally without drainage. If asepsis be perfect, union

should be obtained in forty-eight hours. In femoral hernia, he generally adopts Ball's plan of twisting the pedicle of the sac. He does not often wire the femoral ring, but leaves it to fill by granulation. Umbilical hernia is usually found in women with lax and flabby abdominal walls. The sac is to be extirpated and the margins of the ring brought together in two or three tiers. The truss is not worn after the operation, as its pressure tends to cause absorption of the granulation tissue. He has operated in cases of acute strangulation twenty times, in patients ranging from 6 to 78 years. Of these, four died and one had a relapse; fifty-two cases of deliberate operation for radical cure, all recovered without any sign of disturbance. Of these, fifteen were in females, six of these being umbilical and two femoral. He did not hesitate to operate on both sides synchronously, and had used cocaine.

Dr. McFarlane, Toronto, has had good results from Wood's operation with silver wire. He had operated three times in the Toronto General Hospital, and after two years there had been no relapse. Two operations in his hands by Czerny's method also were successful. He thought the operation was in some respects not so simple as Dr. Park would have us to believe. When the adhesions were old and firm it is very difficult to separate them without lacerating the bowel, and if there are no bands causing constriction it is better to return sac and contents than to run risk of injuring the bowel. If a good truss properly adjusted will keep the bowel reduced, it is preferable to operation.

#### MEDICAL SECTION.

Dr. Holmes (Chatham), chairman.

Dr. R. W. B. Smith (Seaforth) then read a paper entitled,

#### REFLEX NERVOUS PHENOMENA DUE TO PREPUTIAL CONTRACTIONS.

He briefly related a few cases coming under his own observation of nervous irritability in children, arising as a result of narrow prepuce, accompanied with preputial adhesions.

Case 1. A male child, aged 5 months. Parents complain that the child cries almost constantly without any apparent cause; is very fretful and has marked evidence of nervous prostration,



trembling of eyelids, convulsive movements of limbs, etc. On examination Dr. Smith found a pin-hole orifice, with extensive adhesions between the prepuce and glans. He broke down the adhesions and forcibly dilated the prepuce, so that it could be drawn back over the corona glandis; the parts were then thoroughly cleansed. As a result of this small operation, the patient was relieved of all nervous symptoms.

Case 2. A male child, aged 8 months. This child was very fretful, especially during micturition; these symptoms of fretfulness and dysuria had existed for three months. Dr. Smith treated this case by means of gradual dilatation, until the prepuce could easily be retracted over the corona. Result entirely satisfactory; no return of symptoms.

Case 3. Male child. At eighteen months of age showed no inclination to walk; about this time had several convulsions: at the age of three years could scarcely stand; legs were very weak, but not wasted. On general tonic treatment made no improvement. On examination Dr. Smith found an elongated prepuce which was bound down to the glans. He broke down the adhesions and dilated the prepuce until it could be easily retracted; then cleansed the parts. In about a fortnight there was marked evidence of improvement, and from this time the child progressed rapidly; at the end of four months he was able to run about with the other children.

In concluding this paper, Dr. Smith alluded to Mr. Edward Owen's teaching, that a small preputial or urethral orifice, and adherent prepuce were, perhaps, the commonest causes of hernia in children. He also referred to Mr. Bryant's statistics bearing on this same point.

Dr. Newman (New York) made a few remarks highly approving of Dr. Smith's treatment and method of operating, deprecating circumcision in those cases where dilatation is quite sufficient.

Dr. McKinnon (Guelph) read a paper on

#### VENESECTON IN PUERPERAL ECLAMPSIA.

Dr. McKinnon drew attention to the fact that this is no new treatment, but rather a return to old practice. He warned the younger members of the profession against placing any confidence in bromide of potassium, or even chloral, in this critical condition. The inhalation of chloro-

form he considered a very valuable remedy or adjuvant, but would not rely on the fashionable treatment by hypodermatics of morphine. Dr. McKinnon was inclined to believe that venesection saved more lives in puerperal eclampsia than all other remedies. In puerperal eclampsia he believed the patient died from brain pressure, due to serous effusion, hemorrhage, or ordematous infiltration, and that venesection is the most effective method of preventing this brain pressure. Bleed the patient to the extent of a pint or more. As an evidence of this intracranial pressure during a convulsion, Dr. McKinnon referred to the occurrence of sub-conjunctival and retinal hemorrhages which he had frequently seen. Dr. McKinnon did not advocate venesection as a measure to arrest the convulsion, but by diminishing the tension on the cerebral vessels to disarm the convulsion of its fatal power.

Dr. McKinnon gave the following guide to treatment when called to a case of puerperal eclampsia:

1. Bleed the patient, if convulsion be severe or followed by coma.
2. Control the convulsion with chloroform.
3. If patient be at full time, take steps to terminate labor as quickly as possible.
4. Administer an active purgative: Epsom or Rochelle salts.
5. If the convulsions recur, give a large hypodermatic of morphia.

Dr. McKinnon closed his paper with a report of seven cases of puerperal eclampsia occurring in his own practice; they all recovered, venesection being employed in six of these cases.

Dr. Richardson (Toronto) believed venesection to be the sheet anchor in treatment of puerperal eclampsia, not altogether to prevent extravasation, but to reduce the total quantity of poison in the system.

Dr. Holmes (Chatham), in addition to venesection, would recommend the use of diaphoretics; would not bleed in markedly anæmic subjects, but use other remedies.

A paper was read on

#### THE PREVENTION OF PUERPERAL SEPTICÆMIA,

by Dr. A. H. Wright, Toronto. In introducing this subject, Dr. Wright did not think an apology was necessary on the ground that it was

already "threshed out." He maintained that this matter ought to be discussed, until sepsis in the lying-in room becomes practically unknown. "It is anything but creditable to the medical profession that puerperal septicæmia is more common in private practice than in well conducted hospitals; we are not to judge of its effects simply from its death rate, but must also take into account the amount of misery and suffering resulting from the milder forms of septicæmia." Can we prevent this septicæmia? Dr. Wright answered this question in the affirmative. How can it be done? By thorough and perfect cleanliness on the part of ourselves, and the essentials for such are hot water, soap, a nail brush and a penknife. On the part of our patients, proper cleansing of bleeding surfaces, and dressings which will keep them clean, and along with these good ventilation, thorough drainage and perfect plumbing. Dr. Wright cautioned the profession against pinning their faith to any special antiseptic, thinking that by simply using this, dirty hands and dirty instruments could be employed with impunity; at the same time he believed that modern antiseptic remedies furnish invaluable *assistance* in efforts towards asepticism. Dr. Wright then gave the following short account of the methods practised in the Burnside Lying-in Hospital: On admission the patient is bathed and dressed entirely in clothing belonging to the hospital. When labor comes on she is clothed in a clean night dress and drawers. The presentation is made out by abdominal palpitation. Vaginal examinations in the first stage are made occasionally, but as seldom as possible. Each one who touches the patient first washes his hands thoroughly, using soap, nail brush and penknife, and then rinses them out of a solution of bichloride of mercury 1-1000. This process must be repeated before each examination. When the presenting part is pressing on the perineum the vulva is protected by a towel which has been soaked in the bichloride solution. After the delivery of the child no vaginal examinations are made; the placenta is expressed by the Dublin method. The assistant keeps the uterus contracted with gentle rubbing with the fingertips. The soiled clothes are now removed, the nurse washing the vulva with a bichloride solution. No vaginal or intra-uterine douche is

used either before or after delivery. The antiseptic pad is then applied. Dr. Wright here illustrated the making of this pad, which consists of absorbent cotton enclosed in butter cloth; before the dry pad is placed in position, a layer of absorbent cotton wrung out of a bichloride solution is placed over the vulva, the pad lying on this.

Septicæmia in the Burnside has been exceedingly rare during the last few years; the temperature rarely reaches 100° F.; the patients generally go out in two weeks after labor.

Dr. Wright objected to vaginal and intra-uterine douches "because they are unpleasant for the patients, because they interfere with the physiological rest which the torn and bruised parts should have, because septic matter or air may be introduced and brought in contact with rents in the cervix, vagina, or vulva, and finally because they are unnecessary."

He also laid great stress on the danger of introducing the fingers into the vagina after labor; it is entirely uncalled for in the vast majority of cases, the placenta being easily expressed by external manipulations: it is at this stage that septic matter is most readily up taken by the open vessels and the abraded surfaces. He believed that puerperal septicæmia is more frequently caused by absorption of septic matter by the torn fourchette or perineum than from any other source; therefore the practitioner should endeavor to avoid this, by the use of the antiseptic pads and cleansing the vulva with the bichloride solution when the pads are changed.

Dr. Temple considered that there would be very few cases of puerperal septicæmia if the accoucher took all necessary precautions. He also objected to the routine use of douches. In his own practice he never used an antiseptic pad, but simply a clean diaper. He believed that most septicæmic cases were due to absorption of septic matter by rents in the passages.

#### SURGICAL SECTION.

Chairman, Dr. Howitt, Guelph.

A paper on

EARLY OPERATION IN CASES OF OBSCURE ABDOMINAL DISEASE,

was read by Dr. Mitchell, Enniskillen. Experienced surgeons open the abdomen without hesitation, but in country practice cases

frequently arise of such urgency that an operation must be undertaken by one whose experience is limited. Two cases were reported in which, though they ended fatally, there was encouragement from the fact that there was evidence to show that could the consent of friends have been obtained earlier a different result might have been recorded. The first was that of a woman aged 62, who had the usual history of an acute hernia, though no external evidence of hernial protrusion was present. The abdomen was opened antiseptically by a median incision, and upon following the ileum downwards, a knuckle of it was found to occupy an obturator hernia. It was reduced, the patient rallied, passed flatus on the following and fæces on the fourth day. She died, however, on the fifth day.

The second case occurred in an active young man of 16. He was the subject of severe abdominal pain, with high pulse and temperature, and constipation. The abdomen became distended, and an operation resulted in the evacuation of a large quantity of putrid pus from the left iliac region. The abscess had evidently pressed upon the sigmoid flexure sufficiently to cause obstruction. The bowels moved, and he improved for some days after the operation, but ultimately died from exhaustion. Both these cases, the author believed, would have been saved by early operation.

In the discussion which followed, Dr. Mann, of Buffalo, expressed the opinion that operations should be earlier and that more cases should be operated upon. He referred to the difficulty of diagnosing pyo-salpinx, owing to the fact that there is frequently little or no rise of temperature and no other evidence of pus. A previous history of repeated attacks of so-called pelvic cellulitis is usually present. A case of pyo-salpinx of six years' standing, and another of abscess of the ovary, were related in support of early operation. Laparotomy has been successfully performed for general septic peritonitis following labor, by Dr. Evans, of Big Rapids, Mich. One pint of pus escaped and the patient recovered. He has done a laparotomy with cocaine anaesthesia. This may be used if the patient is too weak to stand the shock of a general anaesthetic. If pus is present it is then evacuated, a drainage tube is inserted, and if the patient rallies

the operation may be completed and the cavity washed out.

Dr. Oldright related a case of operation for hæmato-salpinx with recovery. There was a history of chills and sweating, and a diagnosis of pelvic abscess had been made.

Dr. Groves, Fergus, expressed himself as in favor of operation through the vagina in cases of pelvic abscess, as being the shortest way to the pus, and affording the best facilities for drainage.

The discussion on ophthalmology was opened by Dr. Moore, Brockville, who read a paper on,  
GLAUCOMA.

This disease, which is one of the most important and dangerous affections of the eye, frequently comes under the observation of the general practitioner, and it is of the utmost importance that he should make an early diagnosis. The reader of the paper expressed the view that diseases of the eye should be given a more prominent place in the curriculum of our medical colleges and in the council examinations.

The disease is usually met with late in life, and attacks all classes indiscriminately. It may, however, be diagnosed early without the use of the ophthalmoscope, and by attention to its early manifestations scores of eyes may be saved.

The simple chronic form commences slowly and insidiously, and may destroy sight before the patient is aware of its presence. It should, however, be recognized by the surgeon from the increased tension of the eye-ball, the limitation of the field of vision, especially on the nasal side, the hypermetropia, anaesthesia of the cornea, etc.

The acute inflammatory glaucoma is usually preceded by a premonitory stage, and following this there are increased tension, presbyopia, congestion of ciliary veins, and frequently nausea, vomiting and headache. These attacks may result in total loss of sight, and have been mistaken for neuralgia or stomach trouble.

Secondary glaucoma is consequent on some already existing disease of the eye, as tumor, serous iritis, staphyloma, etc.

Hemorrhagic glaucoma is produced by effusions of blood into the retina or optic nerve, or into the vitreous. The reader of the paper then dealt extensively with the differential diagnosis and causes of the disease. The prognosis is

unfavorable, the tendency being in all forms to total loss of sight.

The treatment is not satisfactory, as it rarely results in perfect recovery. The operation of iridectomy may be done in all forms and at all stages, but gives the best results in acute and subacute cases. Sclerotomy is better in cases of simple glaucoma, as it does not disfigure the eye to so great an extent.

Eserine is a valuable drug for lessening the tension. The general health should be attended to, violence and excitement should be avoided, and the digestive tract kept open. Atropia should on no account be used, as it increases intra-ocular tension.

Dr. Burnham, Toronto, thinks that the primary glaucoma is of most interest to the general practitioner, as the secondary affection soon drives the patient to the specialist on account of the severe pain.

Primary glaucoma may be divided into the acute and chronic. The acute usually commences with well-marked symptoms and great severity. It simulates an exceedingly acute bilious attack. The headache is very great, and serves to divert the attention of the patient from his eye, so that he may become quite blind before he is aware that there is anything the matter with the eye. The disease may escape the attention of the practitioner from the same cause.

If not attended to early it will be necessary to remove the eye. The chronic form presents another danger. It simulates cataract, and as dimness of vision, without pain, is what is complained of, the patient may be advised to await the "ripening" of the cataract, so that when he comes to the specialist the sight is usually already gone.

Dr. Palmer, Toronto, recommends a hypodermic of morphia to relieve the severe pain that is sometimes present. Iridectomy in preference to sclerotomy is the operation to be performed in most cases.

Dr. R. A. Reeve, Toronto, considered the secondary or consecutive glaucoma as of more importance to the general practitioner than the primary, owing to the rarity of the latter. Eyes may be lost from a glaucoma secondary to an ulceration of the cornea, or an interstitial syphilitic keratitis. Perforation of the cornea with prolapse of the iris, and subluxation of the

lens, are frequently followed by the hard globe of glaucoma. Acute glaucoma may be detected by the hardness to touch, the dilated pupil, and the limitation of the field of vision on the nasal side. The development of glaucoma in ulceration of the cornea in infants should be watched for. Eserine is the sheet-anchor in the treatment, acting by relieving tension.

#### *Evening Session.*

Dr. Skene, Brooklyn, N.Y., read a paper on

#### INTRA-LIGAMENTOUS OVARIAN CYSTOMA.

This term embraces only those cysts which are developed from the ovary and situated completely within the folds of the broad ligament, being thus neither pedunculated nor provided with a sessile attachment, but surrounded by a capsule formed from both folds of the broad ligament. These cysts are developed either from the parovarium or from the ovario-phoron—generally perhaps from the paroophoron.

The cysts so situated are comparatively rare, and two theories have been advanced to explain their unusual position. The first assumes that the ovary itself is placed between the folds of the broad ligament from developmental error. The second theory is that the cystoma burrows during its growth into the ligament. In order that this may come about, it is necessary that the ovary, by a special formation, be closely attached to the ligament, or fixed there by inflammatory adhesions. The latter view is supported by some observations in the author's cases. They are generally mono-cysts, though some are multiple. There may also be proliferating or papillary cysts—a fact accounted for by Bland Sutton by their development from the deeper structures of the ovary—the paroophoron.

The position of the cysts with reference to the other pelvic organs is of interest. They may be in one ligament, displacing the uterus and bladder to the opposite side of the pelvis, or they may occupy a position in both ligaments, between the uterus and the bladder, which are in these cases carried by the tumor high up out of the pelvis, so that the most dependent portion could not be easily reached through the vagina.

Again, the tumor may be behind the uterus and yet within the folds of both ligaments. In this case the pelvic organs are carried out of the

pelvis, but the tumor occupies the pelvic floor. These facts regarding their anatomical relations are of the utmost importance in regard to their surgical treatment.

As a point in diagnosis, they are generally accompanied by more distressing pains in the pelvis, and more disturbance of the functions of the bladder and rectum than are ovarian or par-ovarian cystomata.

Physical examination shows that the cyst is fixed at its most dependent part, the fixation being at one side or extending from side to side according as the tumor occupies one or both ligaments. Fluctuation is noticeable in the pelvic portion of the tumor. The points of diagnosis from fibro-cysts, which they most closely resemble, were given in detail. The cystoma in one ligament only must be distinguished from intraligamentous uterine fibroma, hydro-salpinx and ectopic gestation. It is occasionally impossible to make a diagnosis upon evidence obtained by the history, symptoms and physical signs, and in these cases an exploring laparotomy should be advised. Even then it is not always an easy task to complete the diagnosis.

Among the various methods of treatment, enucleation, as devised by Dr. Minor, of Buffalo, ranks first, as it is applicable to more cases than any other. This plan is adapted to all cases in which the cystoma descends into the pelvis, completely separating one or both ligaments, unless there are inflammatory adhesions between the cyst wall and the ligaments. The operation of enucleation was described in detail, and drainage of the pouch advocated. The peritoneal surfaces of the edges of the pouch are brought together by a continuous catgut suture, and brought up and fastened to the peritoneal edge of the abdominal wound, if possible.

The next method is to remove the cyst and capsule together by ligating the ligaments below the cyst, by means of the "repeated continuous ligature." A combination of these two methods is sometimes practised, namely, enucleation followed by ligation and removal of the pouch.

There are, unfortunately, some cystomata of this variety which cannot be removed by any of the methods known at the present time. These should be treated by drainage alone, uniting the cyst to the abdominal wall, after removing as much of the cyst as possible and thoroughly

cleansing and scraping out the remainder. The drainage must be long continued and the convalescence is slow.

(To be continued in next issue.)

## Correspondence.

Editors of CANADIAN PRACTITIONER.

DEAR SIRS—In the issue of your journal of May 16, 1889, I notice an editorial headed "Length of the Course of Medical Studies," in which you state that "for many years the University of Toronto stood alone in its rigid adherence to the rule requiring a full four years' attendance on lectures," and also that "from information *lately received*" (the italics are mine) "you are encouraged to hope that the other universities are likely to follow the example of Toronto, and demand four years' actual attendance on lectures." All honor to the University of Toronto for demanding a full four years' course, but it must be remembered that, until very lately, the medical department of Toronto University was purely an examining board, and that the Toronto School of Medicine did not require, as far as I am aware, this compulsory course until it became a faculty of the University; besides, even now, I believe, the University of Toronto does not require a four years' course when the candidate holds the degree of B.A. Of these facts, no doubt, sirs, you are fully aware, but you are evidently not aware (or you would have mentioned it in your editorial) of what the University of McGill College has done and is doing to advance the cause of medical education. Since 1884 she has required not only four six months' sessions, but also one three months' summer session, in order to qualify for the degree of M.D., and no exception is made in the case of men holding the degree of B.A. The advisability of making two summer sessions compulsory is now under consideration.

Trusting that in future your information about other universities in Canada will be more "lately received" than that disclosed in the editorial above referred to, and hoping that I have not intruded too much upon your valuable space, I am, sirs,

Yours truly,

FRANCIS J. SHEPHERD, M.D.

85 Mansfield Street, Montreal.

## Books and Pamphlets Received.

*Scarlatinous Otitis.* By Chas. H. May, M.D. (Reprint.)

*Is more Conservatism Desirable in the Treatment of the Joint Diseases of Children?* By A. B. Judson, M.D. (Reprint.)

*Proceedings and Addresses at a Sanitary Convention held at Hastings, Mich., Dec. 3 and 4, 1888.* Lansing: D. D. Thorp. 1889.

*A Resumé of Experience at the Aural Clinic of Prof. Hermann Schwartz in Halle, Germany.* By Chas. H. May, M.D., New York. (Reprint.)

*Preliminary Report of The Illinois State Board of Health. Water Supplies of Illinois, and the Pollution of its Streams.* By J. H. RANCH, M.D., Secretary, Springfield, Illinois.

*Second Biennial Report of the North Carolina Board of Health of the General Assembly of North Carolina. Session of 1889.* Raleigh: Josephus Daniels, State Printer and Binder.

*Du Rôle de l'Hérédité Dans l'Alcoolisme.* Par Paul Sollier, Interne des hôpitaux de Paris. Un volume in-18 Jésus.—Prix: 2 fr. 50. Vient de Paraître Aux bureaux du *Progrès médical*, 14, Rue des Carmes.

*Strathpeffer Spa, its Climate and Water, with Observations, Historical, Medical and General, Descriptive of the Vicinity.* By Fortescue Fox, M.D. (Lond.) Illustrated. London: H. K. Lewis, 136 Gower St., W.C. 1889.

*Maladies de la Langue.* Par le Dr. Henry T. Butlin, Chirurgien assistant et professeur de Chirurgie pratique et de Laryngologie à Saint Bartholomew's hospital, Traduit de L'Anglais. Par le Dr. Douglas Aigré, Ancien interne des hôpitaux de Paris. Un beau volume in-80 de 430 pages.—Prix: 8 fr. Vient de Paraître Aux Bureaux du *Progrès médical*, 14, Rue des Carmes.

*La 4<sup>me</sup> édition Revue Augmentée du Manuel Pratique de la Garde-Malade et de l'Infirmière* Publie par le Dr. Bourneville, Médecin de Bicêtre, Directeur des Ecoles municipales d'Infirmières. Avec la collaboration de MM. Blondeau, de Boyer, Ed. Brissaud, Budin, P. Keraval, G. Manoury Monod, Poirier, Ch. H. Petit-Vendol, Pinon, P. Regnard, Sevestre, Sollier et P. Yvou.

Cet ouvrage, adopté par Les Ecoles Départementales et Municipales d'Infirmiers et d'Infirmières du département de la Seine, est divisé en

trois volumes dont les titres suivent: Tome 1, Anatomie et Physiologie, Pris 2 fr.; Tome 2; Administration et comptabilité hospitalière, Prix 2 fr.; Tome 3, Pansements, Prix 3 fr.; Tome 4, Femmes en couches: Soins à donner aux aliénés; Médicaments, Petit Dictionnaire, Prix 2 fr.; Tome 5, Hygiène, 2 fr., Les cinq volumes réunis, Prix 7 fr; 50.

Vient de Paraître, Aux bureaux du *Progrès médical*, Paris, 14, rue des Carmes, Paris.

## Births, Marriages and Deaths.

### BIRTHS.

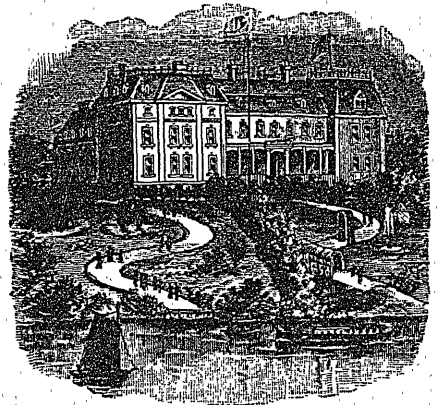
WRIGHT.—On June 6th, 1889, at Oak Lake, Manitoba, the wife of Dr. H. A. Wright, of a son.

RIORDAN.—At 384 King Street West, Toronto, on Thursday, June 13th, the wife of Bruce L. Riordan, M.D., C.M., of a son.

MACDONALD.—At 180 Simcoe Street, Toronto, on Wednesday, June 12th, the wife of Albert A. McDonald, M.D., of a son.

### MARRIAGE.

PRIMROSE—EWART—On Tuesday, 11th June, at the residence of the Hon. Oliver Mowat, uncle of the bride, by the Rev. Prof. Mowat, D.D., Alexander Primrose, M.B., Edin., to Clara Christina, daughter of the late George Ewart, Esq.



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FRED. J. STEWART, Sec.-Treas.