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THE CANADA LANCET,

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Original Communications.

INTUSSUSCEPTION OF THE ILEUM.

BY W. A. WILLOUGHBY, M.D., COLBORNE, ONT.

I was called on Wednesday, Oct. 31st, at 11 a.m., to see Mr. S., aged 63, who had been seized suddenly with pain an hour before while in the field assisting his men in digging a ditch. He had been engaged in the same work for some days previously without suffering any inconvenience—and none was felt up to 10 a.m. the time of the attack. He was as well as usual in the morning; eating his breakfast heartily and having had a free evacuation from his bowels. I found him in extreme torture, complaining of constant and continuous pain in the lower part of the abdomen, localized if at any spot in particular, a little to the right of the median line, about half way between the umbilicus and the pubes, not enough to the right side, however, to make one suspect trouble at the ileo-cæcal orifice—though when asked to point out the seat of pain he would pass his hand over the whole pubic region. Accompanying the pain were violent attacks of vomiting occurring every few minutes, the ejected matter being mucus and bile. Superficial examination of the abdomen, the walls of which were quite lax, revealed nothing suggestive, and nothing was discovered by digital examination per anum. The urine was voided freely. There was no hernia. The heart's action was somewhat hurried, the pulse being 80, and intermittent, dropping a beat in every 8 or 10.

I put the patient on Hoffman's anodyne in such doses, 10 minims of chloroform being added to each dose. This quantity was repeated every fifteen minutes for the first hour. I also gave him an injection of warm water, to which was added soft soap and castor oil. This emptied the bowels thoroughly. The patient was grow-

ing worse, pain becoming more severe, notwithstanding, I had used hypodermically $\frac{1}{4}$ grain of morphine. He lay on his back keeping his body perfectly motionless, and his suffering was very acute. As I feared the case would prove to be one of invaginated bowel, I gave a copious injection of warm water (3 quarts), in which was dissolved 25 grs. of extract of belladonna. I passed this up slowly and had it retained for fifteen minutes, when I allowed it to come away, which it did without carrying any fecal matter with it. I gave by the mouth, 15 grs. of calomel and $\frac{1}{2}$ grain of morphine, believing it would have the best chance of remaining on the stomach. I left a similar powder, to which was added 5 grs. of jalapine, to be given in two hours after previous one, and directed that he should have free injections of warm water every two hours. I left at one o'clock and did not see him again until seven, when I found that the instructions had been followed with out any benefit as far as the bowels were concerned—though the pain was lulled somewhat. I remained five hours with him—at times patiently kneading the bowels, again giving injections, to some of which I added extract of belladonna, placing him on his right side with his shoulders low down and his hips elevated as much as possible,—without any change in his condition. I left him at midnight with orders that nothing was to be given till six in the morning when I saw him. He had used the bed-pan twice without having anything pass his bowels, though the urine had passed freely.

Upon manipulation of the abdomen now, a distinct enlargement could be felt in the right inguinal region, apparently about the ileo-cæcal orifice, a couple of inches from this, and directly to the left or it, another enlargement could, with difficulty, be made out. This last was very painful—the former not at all painful on pressure. I gave an injection every two hours—the bowels to be rubbed gently with the hand at intervals during the day.

The pulse was now about 100. The vomiting was persistent, but not stercoraceous; no fecal odor from the breath. I saw him in the evening, when I had the pleasure of meeting Dr. McDonald, of Brighton, and Dr. Gould, of Colborne. The enlargement first mentioned, in the inguinal region had entirely disappeared, but his condition had grown rapidly worse. His pulse was almost in-

perceptible at the wrist. The extremities were cold in spite of every applied means to restore warmth. We considered his case hopeless—in fact he was in a state of collapse at the time—and nothing to what had been resorted to in the case could be added. There was a fæcal odor from the last ejecta from the stomach. We gave him half a grain of morphine and ordered brandy every half hour, which he could not keep down, as I learned in the morning. From his condition at this time, we did not think it possible for him to last another twelve hours.

I saw him in the morning, Friday, Drs. Thorburn, Powers, and Gould, seeing him with me during the day. His condition was very much changed since last night. He was now perfectly easy, not having any pain even on manipulation. Extremities warm; stomach quiet; heart's action easy and natural; pulse 90 and perfectly regular, its intermittency having ceased with the cessation of pain. As he was in such a comfortable condition, we decided to let him alone for the day, which we did, and see him next morning (Saturday).

This morning, as the bowels were much distended and tympanitic, we decided to give him a much larger injection than he had as yet. Two gallons were slowly passed up, the anus being aided in retaining it by a napkin firmly pressed against it. With this quantity of fluid in the bowel, we raised him into a perpendicular position, heels up. While gently rubbing the bowels before letting off the injection, we had the satisfaction of seeing him make a start as if something had given way. Pressure being removed from the anus the fluid came away as if driven by a force pump. With the last of it there were a couple of fecal casts and a quantity of dark grumous matter. There was a distinctly gangrenous odor from the expelled contents. We repeated the injection in two hours. This likewise carried away a quantity of the same well pronounced gangrenous matter. We left him and returned at night to find him sinking. He had had a couple of motions, principally grumous matter and blood since morning. He passed a quiet night and lived till two o'clock on Sunday afternoon. He is the fourth of the same family that has fallen a prey to this intractable affection. Two sisters and two brothers (and also a son of one of the sisters), died from intussusception.

Autopsy, 42 hours after death. Abdomen very much distended, upon making usual incisions found tissues perfectly healthy. Upon raising ileum found indications of disease about 12 inches from the ileo-cæcal orifice. This part of the small intestine was empty, as also the large intestine; above the diseased portion the small bowel was filled with fluid fæces. Removed the implicated portion, which we afterward found to be by measurement 18 inches. On the outside of the incarcerated part and for some four inches above and two below, the whole surface was intensely engorged with blood. The sheath over the invaginated part was just five inches long; on the cæcal side of injury there was a ruptured band of about one-half inch in width. This was evidently what had given way during the injection; on the upper side there was a firm band one inch in width. This band was very firm and directly above the commencement of the sheath.

Slitting the bowel up from the lower extremity to the upper limit of the sheath we found a loop of bowel completely encased. This loop of intestine measured nine inches. The mucous coat of the bowel was engorged till it seemed a mass of blood. There were a number of gangrenous patches, one of which was much more advanced than the others.

The patient just lived 100 hours from the commencement of the attack; mind perfectly clear to the last.

REMARKS.—The only benefit that treatment had given in this case, which the autopsy revealed, was the rupture of the lower encircling lymph band. The quantity of water (two gallons) passed up at one time, in order to accomplish this, may give a proximate idea of the quantity required to be of any use in similar cases. It will be observed that with this quantity the ileo-cæcal valve was passed by a sufficient quantity to distend the ileum between this valve and the obstruction.

Attentive consideration of this case prior to and after death has satisfied me that we have nothing successful to hope for, from any treatment short of operation, and if a second one of this peculiar nature should come under my care I shall promptly cut down at the earliest possible moment, after which I am satisfied of the nature of the trouble. An operation to be of any use must be resorted to, before the lymph bands have become organized.

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be in this family that so many should fall a prey to incarceration of the bowel? The only thing particularly observable in this individual case was the great quantity of tissue in the longitudinal muscular coat of the intestine.

GENITAL IRRITATION AS A CAUSE OF NERVOUS DISEASE.

BY GEO. M. AYLESWORTH, M.D., COLLINGWOOD, ONT.

My attention was called to this matter by an article in the *American Journal of Medical Sciences* for October, 1876, written by A. McLane Hamilton, M.D. I must refer those interested to Dr. Hamilton's article for an exposition of the physiological principles that underlie the train of symptoms noted. He mentions Dr. Jacobi and Dr. Sayre as almost the only observers who have directed attention to the subject, and states that the latter gentleman has reported ten cases in which the condition was recognized. To these, Dr. Hamilton adds four more reported in the article above mentioned, and he divides the neuric symptoms arising from this condition as follows:

First, those expressed by want of muscular power,—Paresis, including paraplegia and partial paresis of isolated groups of muscles; paresis of the muscular fibres of the bladder.

Second, Sensory—Hyperæsthesia, anæsthesia, dysæsthesia.

Third, Vaso-motor—Priapism, local hyperæmia.

Fourth, Hyperkinesis—Choreic movements, transitory contractions.

Fifth, Physical disturbances—Loss of consciousness, impairment of memory, irritability of temper, melancholia, dementia.

The patient may present many of these symptoms at the same time. C. S., a boy about five years of age, a case under my observation, the symptoms when first seen were.

First, those expressed by want of muscular power,—Partial hemiplegia. The paralysis being complete in the left side of the face and in the extensor muscles of the left fore-arm; partial in the tongue and the extensor muscles of the left leg. The flexors were not affected; there was atrophy of the affected muscles which was nothing like so great in the opposing groups, although existing to some extent.

Second, Sensory—Hyperæsthesia.

Third, Vaso-motor—Priapism, almost constant.

Fourth, Hyperkinesis—Transitory contractions, occurring when he lost consciousness.

Fifth, Physical disturbances—Loss of consciousness, occurring as often as every five minutes for several hours at a time. It was only momentary, but complete. These attacks were epileptoid in character, and his parents had come to denominate them as *spells*. Irritability of temper.

There was also adduction of the left leg and contraction of the sural muscles, drawing up the heel of the left foot. The eyes were constantly twitching, and during the *spells* were drawn violently to the left.

When the child was about two years of age, and residing in the Western States, the parents had first noticed these attacks, and they constantly increased in number and severity, notwithstanding he had taken a great many courses of medicine for nervous disease under the direction of a number of medical men, both in the United States and Canada, the genital organs having been entirely overlooked. Upon examination marked phymosis with a prepuce in a high state of irritation was noted. I performed circumcision; the wound did not heal satisfactorily, and it was several weeks before it was entirely closed. It was several weeks after this event before the epileptoid attacks ceased entirely; although slight, the changes in his condition were sufficient previous to this to encourage me to hope for ultimate success. Having once ceased, they have not returned except for a short time while the patient was suffering from derangement of the stomach and urinary organs, which yielded rapidly to treatment.

The present state of the patient one year after operation:—

First, those symptoms expressed by want of muscular power—Paralysis of face and tongue absent, not quite so marked in arm and leg. Patient frequently in walking, places left foot squarely on the floor.

Second, Sensory—Absent.

Third, Vaso-motor—Absent.

Fourth, Hyperkinesis—Absent.

Fifth, Psychical disturbances—Absent. Eyes normal.

The patient has grown very rapidly, and is very hearty looking. The affected side has kept pace

with the general growth. The atrophied groups of muscles are improving, but the disproportion is still very marked. By comparing the state of the patient now and at the date of the operation, it will easily be seen that the change is complete, except in those parts where organic change had taken place (the atrophied muscles) before the application of the remedy. And the changes here in so short a time have been so great, that they give us reason to hope for a complete recovery in the end.

As there was no medical treatment except such as was required to keep the system in its ordinary health, the change in the patient's condition can only be ascribed to the operation relieving genital irritation, or a remarkable coincidence.

A NEW METHOD OF TREATING FRACTURE OF THE CLAVICLE.

BY HENRY VANBUREN, M.D., CHICAGO.

(Also published in *Chicago Medical Journal*.)

While one of the visiting physicians of the Central Free Dispensary about three years ago, I treated a patient for fracture of the clavicle, adopting the plan of my friend Dr. Lewis A. Sayre, of New York, using two strips of adhesive plaster without any axillary pad. I became convinced at once, that the principle advocated by Prof. Sayre, was undoubtedly the correct one; but before I had gone very far in the use of the adhesive strips, I found that my patient, a young native of Ireland, began tearing them off. The weather was warm, and, to use the language of the lad, they "itched him." Finding this difficulty in holding the arm and shoulder back by a hitch around the body with adhesive plaster, the thought struck me, that I would make a hitching post of the sound shoulder instead; not as in the old plan of a figure of eight around both shoulders, but upon that which I will now lay before my brethren in the profession.

To make known my plan in a sentence—I make attachment to the middle of the arm on the fractured side; draw the arm backward until the clavicular portion of the pectoralis major muscle is put sufficiently on the stretch to overcome the sternocleido-mastoid, and then make a hitching post of the sound shoulder to hold these muscles in exten-

sion, and by this extension with the sling, which will be hereafter described, the ends of the fractured clavicle are held in apposition. I make the first bandage three or four inches wide out of unbleached cotton, of double thickness and sufficient length. On one end of this bandage a loop is made, by returning the bandage on itself, and fastening the end with a few stitches. The hand on the injured side is then passed through this loop, and the loop carried up to a point just below the axillary margin. This bandage is then passed directly across the back, and under the sound arm and over the sound shoulder, and returned obliquely across the back, and pinned or stitched to itself at the point where the loop is formed. See figure 1.

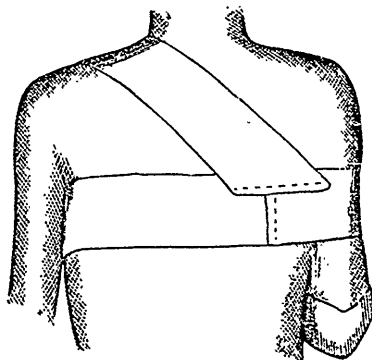


Figure 1. VanBuren's first Bandage for Fractured Clavicle. Back view.

The second bandage is then made and applied as follows: Flex the arm of the injured side, and place the hand on the chest, pointing in the direction of the sound shoulder; then take a piece of the same material as used in the first instance, and make a bandage four inches wide, of double thickness and sufficient length, and pin or stitch one end of this bandage to the lower margin of the first bandage, in front of the sound shoulder. It is then passed diagonally downward, and across the chest under the hand and forearm which has been flexed upon the chest, and carried around the arm at the elbow, and back on the dorsal surface of the forearm and hand to the point from which it started, and this end also pinned to the first bandage. The lower margins of this bandage are then stitched together for a distance of about three inches at the elbow, thus forming a trough for the elbow to

rest in. The same is also done at the upper end of this bandage, which forms another short trough for the hand to rest in. See figure 2.

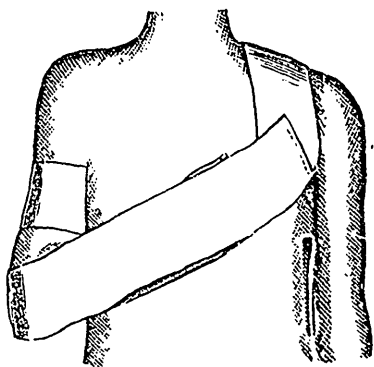


Figure 2. VanBuren's second Bandage for Fractured Clavicle. Front view.

This bandage or sling may be made as described above, before it is applied, and the elbow placed in the lower trough and the hand in the upper one; and the upper ends of the bandage pinned to the lower margin of the first bandage, at a point opposite the sound shoulder, as above indicated; indeed I prefer this plan because more convenient. This sling serves the triple purpose of drawing the lower end of the arm forward and upward, and thus throwing the injured shoulder backward. It supports the forearm and hand in a comfortable and quiet position, and last, it prevents the first bandage from cording under the sound arm by its attachment to its lower margin. To prevent the bandage from producing excoriation in the axilla of the sound side, I usually cushion the bandage at this point by stitching on two or three extra thicknesses of the cotton cloth. The same may be done at the loop,—around the arm of the injured side, if necessary. What is presented, then, for the consideration of the profession in this method is—

- 1st. The great simplicity of the appliance.
- 2nd. The complete retention of the fragments in apposition.
- 3rd. The comparative ease with which the bandage is worn.

The deformity which takes place in fracture of the clavicle is too well known to require any description, viz.: that the shoulder falls downward, forward and inward, and that the outer end of the sternal fragment overlaps the inner end of the

acromial portions of the clavicle. The indications to be fulfilled in the treatment are also well known, viz: to draw the shoulder upward, outward and backward, and retain it there, and thus by virtue of this position, hold the fractured ends in apposition. It will be observed that the first bandage, as presented in Fig. 1, not only draws the shoulder backward, but has a lifting tendency, the bandage being at a higher point, where it passes over the sound shoulder than where attached to the arm on the injured side, hence the shoulder is drawn upward; also that the deltoid and biceps muscles are quieted by the loop around the arm. Let the surgeon himself stand erect and thrust backward and upward his own shoulder, the one supposed to be the injured one, and flex the fore-arm upon the chest, with the hand pointing in the direction of the sound shoulder, and he has at once secured the position and fulfilled all the indications desired in fracture of the clavicle; and the bandages presented in this paper retain this position in a very simple and practical manner.

A patient of mine under treatment for this injury, was brought before the Chicago Medical Society, at one of its regular meetings in May last, after union had taken place; and I think the gentlemen who were present can say that there was little or no deformity in the case before them. I also had the privilege of doing what was so much desired before submitting this paper for publication, that of bringing this method before a number of surgeons of high standing in the profession, at the late meeting of the American Medical Association, among whom were Dr. Lewis A. Sayre, of New York; Drs. Gunn and Powell, of Chicago; and Drs. Bridge and Hyde, associate editors of the *Chicago Medical Journal*, who approved of the plan laid before them. I was eager for the opinion of Prof. Sayre, who was the first to put into practice the principle laid down in this method, and the plan received his hearty approval. I have treated every case of fractured clavicle upon this plan, which I have been called upon to attend for the past two years, modifying the appliance from time to time, until the indications sought after were more perfectly acquired. At the beginning of the third week, or earlier, the bandages should be removed occasionally, and passive motion of the elbow and shoulder made. I am of the opinion that judicious movement of all fixed joints is

too long delayed by most surgeons in cases of fracture. In the fracture presented in this paper, with the bandages used, early movement is indispensable, inasmuch as the parts are held so completely at rest.

And now, if any apology is needed for trying to present a new way of treating this fracture, it must be found in the fact, that we think the old plans were failures, notwithstanding the many and complicated means devised to secure retention. Dr. Sayre has quoted, in his pamphlet on this fracture, from a dozen authors, running back to the days of Hippocrates, showing that this injury has always been attended with deformity. In Prof. Hamilton's work on "Fractures and Dislocations," the author quotes from fifty-seven different authors, to sustain his own observations, that this fracture is nearly always followed by deformity. Miller, Ferguson, Simpson, Hancock, South, and many others of England, and a grand array in other countries, have all had their wedge-shaped pads, and never-ending turns of the bandage around the body, but I cannot see that they accomplished more than to keep the fracture quiet, and thus facilitate a kind of union with, as they all acknowledge, more or less deformity.

South says that he does not like any apparatus which draws the shoulder backwards. If the author means both shoulders, we are agreed; but I want one shoulder, and that the injured one, drawn backward, and well backward at that,—for herein we get extension and counter-extension too, if you please, the thing so essential in fractures of all long bones, and we cannot get this in any other way. The pad under the arm does not cause adequate extension, nor will it ever do so, no matter how large or in what manner placed. The figure of 8 bandage of modern use, is exceedingly objectionable, for one important reason, if for no other. If the fracture is in the middle third of the clavicle, or near the middle at all, the bandage presses down over the site of injury, and particularly over the inner end of the outer fragment, the very end already dragged down by the weight of the shoulder, and just here is one of the valuable points in what we have termed a new method. The injured shoulder is entirely free from any depressing or other bandage. I do not even allow the patient to wear a suspender over the injured shoulder.

The "pos:ural position" might do quite well for

an indolent man, but even then we might fail in getting union; again, this is an age of fresh air and hygiene, and every patient, as far as practicable, should have the advantages of out-door exercise. I am no stickler for any kind of apparatus in the treatment of fractures, any more than I would be for any particular medicine in disease. Whatever accomplishes the end in the most simple manner under existing circumstances, is generally, if not always, the best, and the plan for treating fractures of the clavicle, as presented in this paper, is in keeping with this doctrine, and is brought before the profession with confidence, and in the belief that a good result can be attained in the hands of any surgeon, if the method is faithfully and intelligently carried out.

TRANSLATIONS FROM FOREIGN JOURNALS.

BY _____, M.D.

POISONING BY SALICYLATE OF SODA. — Dr. Peterson (*Deutsche Med. Wochenschrift*) mentions a case in which salicylate of soda was given by mistake to the extent of 26 grames (390 grs.) in 12 hours. The patient was a young girl about 15 years of age, who had been operated upon for resection of the ankle joint. Fourteen days after the operation, she was given the salicylate of soda as above stated, and very soon toxic symptoms manifested themselves, similar to those observed in experiments on animals. The brain symptoms were the most prominent and persistent. There was delirium, difficulty of hearing and ringing in the ears; she was perfectly rational at times, and then complained of severe headache; could not see distinctly at a distance. There was strabismus and extreme mydriasis. The delirium lasted 8 days and was of a melancholy nature. During this time she had no recollection of what transpired. The temperature was not affected. There was hoarseness for four or five days; the respiration increased to 40 per minute, and the skin was covered with a profuse perspiration. There was considerable disturbance of the vaso-motor system, and dilatation of the blood-vessels in different parts of the body was noticed.

EPILEPSY CAUSED BY A LARGE FIBROMA OF THE

LARYNX.—*Berliner Klinische Wochenschrift*, No. 39) The case of fibroma of the larynx is described and illustrated by Dr. J. Sommerbrodt. The patient was 54 years of age, and had been troubled with hoarseness since 1867. In 1874 he came under the notice of the Dr. who examined the larynx with a laryngoscope, and he discovered a large polypoid growth which was attached to the left vocal cord, especially over its anterior part. It also grew half way over the rima glottidis; was red in color, firm, and attached by a broad base. The hoarseness increased until Feby., 1875, when epileptiform convulsions commenced to show themselves, especially at night. These gradually increased and finally there was slight paralysis of the left arm, leg, and face. The fits became more frequent as the tumor enlarged, and occurred during the day. The ordinary remedies had no effect in reducing their frequency. The Dr. tried to snare the tumor ineffectually for several days in succession. On the fifth day he succeeded in cutting away with a sickle-shaped knife having a probe point, a small piece, and the next day the whole tumor, which was caught and spat up almost immediately—except a small fragment in the anterior part of the larynx, which was subsequently removed with small forceps. Very little hemorrhage followed the operation. The tumor measured 1 inch in length, $\frac{1}{4}$ inch in width, and $\frac{1}{3}$ inch in thickness. It was wedge shaped, and presented numerous small outgrowths or papillary eminence on its surface. The patient made a good recovery and was entirely relieved of his epilepsy. He has had no return of the disease since. The author calls it a case of sympathetic epilepsy.

REMOVAL OF THE UTERUS IN CASES OF CHRONIC INVERSION—IRREDUCIBLE.—(*Archives de Gynécologie*).—M. Donné in a communication to the Academy of Sciences, Paris, gives the following conclusions:

1. External hysterotomy is an extreme surgical resource, but precious for cases of irreducible inversion, which threaten immediately the life of the patient.
2. This operation does not furnish a greater mortality than that of the greater number of grave operations.
3. In the actual state of science, it ought to be made preferably by the ligature, bearing in mind the perfection attained by this method.

4. For the first months of an inversion—even the first year as far as possible, repeated tentative efforts at reduction, lactation which generally suppresses the hemorrhages, and all sorts of palliative methods, should be fairly tried.

The operation ought to be reserved for cases recognized as irreducible, and for the period remote from the commencement of the malady, when involution has completely taken place, and the neighboring organs have undergone changes rendering the risk of peritonitis much less, this being very important.

JUNIPER LEAVES IN PRURITUS.—Prof. Boeck (*L'Union Médicale*), recommends juniper leaves for the itching which accompanies pruritus, urticaria, prurigo, eczema, and other cutaneous affections. The appliance for using them is similar to that of a vapor bath. The patient is shut in a box fitting closely around the neck, and under him is placed some red-hot charcoal, upon which are strewn some juniper leaves, fresh or moistened with water. He is exposed to the vapor so produced for 20 or 30 minutes and this should be repeated every second day. In some of the above mentioned diseases it succeeds admirably, in others especially in chronic cases, its efficacy is not so well established. This treatment, the writer says, has permanently cured some obstinate cases of pruritus and urticaria.

TREATMENT OF PLEURISY WITH EFFUSION.—Dr. Heitter (*Allg. Med. Cent. Zeitung*) writes an able article on the above interesting subject. The author states his opinion that we can not by medicinal agents, to any great extent, produce absorption of the exudation, and that therefore, after an expectant course of a few weeks, recourse should be had to thoracentesis. The instruments he uses are of the simplest kind, which he strongly recommends in all operative procedures. He uses only a trocar, bistoury, rubber tube, and syringe. He does not consider the aspirator at all necessary, and would use it in old persons where the elastic force of the chest is not sufficient to force the fluid out. In cases of pyæmia he opens the chest by an incision two and a half inches long at the lowest point, and subsequently washes out the cavity with carbolized water by means of an irrigator and a caoutchouc tube, which is pushed into the deepest point of the pleural cavity. He considers

that in pyæmia a free opening is preferable to all other methods.

In serous exudation he thinks thoracentesis is not required if the fluid extends no higher than the middle of the scapula but that that it will become absorbed without danger to the patient. If on the other hand one side of the chest is filled and there is pressure on neighboring organs, an immediate operation is called for. When the fluid accumulates slowly he would not consider it too long, to wait two or three weeks to see if absorption will not take place spontaneously. He considers it advisable to ascertain as soon as possible, however, whether the exudation is serum or pus. This may be done by means of a hypodermic syringe. If blood is found to exist it indicates an unfavourable case; the prognosis is bad. The author also alludes to the fact that thoracentesis for the most part not serious, is not entirely free from danger, especially in persons who are weakened by long continued disease.

HYPODERMIC INJECTION OF ERGOTIN IN HEMOPTYSIS.—Dr. Hirschfeld (*Wiener Med. Presse*) after alluding to the use of cold in the form of ice, alum, acetate of lead, tannin, chloride of iron, &c., says the sovereign remedy for hemoptysis is the hypodermic use of ergotin, which acts as a vaso-constrictor. Drasche was the first to use ergotin in this way in 1871. It is rapid in its action, and easily introduced as compared with the inception of medicine by the stomach under such circumstances. It is administered in solution with glycerine 1 to 10. To prevent any irritation by reason of the puncture, and to allay irritability of the nervous system frequently present in hemorrhages, and procure rest, he precedes the injection by one of morphia, or adds morphia to the solution of ergotin.

Correspondence.

To the Editor of the CANADA LANCET.

SIR:—With reference to the note in your last issue from my esteemed friend Dr. Daniel Clark of the Toronto Lunatic Asylum, claiming priority in the operation of hysterotomy in Canada, I must cheerfully concede that claim, *quo ad* myself. Dr. Clark's operation preceded mine several years—the one performed by me being on the 28th September, 1871.

Your obed't servant,
WM. H. HINGSTON.

MONTREAL, Nov. 6th, 1877.

Selected Articles.

TUBERCULAR MENINGITIS.

This disease is usually spoken of as one chiefly confined to children, though most authors recognise it as occurring in adults, but as rare in them. The most recent text-book (Roberts) teaches students that though mostly seen in children between two and ten years of age, it may be met with from earliest infancy to old age. A very good description is given by Dr. Roberts, in which it is manifest that he is writing from it affecting children. Then he turns to the disease in adults, and says that it is usually considered as *secondary*, though Gee thinks it as common *primary*.

The symptoms are said to resemble those of the affection in children, the most prominent being severe frontal headache, with darting paroxysms, heat of head with redness of face, or alternate flushing and pallor with suffused conjunctivæ; often dulness and mental confusion, tending to somnolence or stupor alternating with delirium; indisposition to speak, sometimes sudden aphonia; photophobia and intolerance of sound; twitchings, ptosis, or other evidence of irritation of the cranial nerves; convulsion, paralysis, cerebral vomiting; coma follows.

Such are the ordinary symptoms, but they vary much in different cases. Hence the disease, very frequently, is not recognised during life. The text-book we have cited contains as much as may be expected to be known to the majority of practitioners. A much more elaborate account of our knowledge on the subject has been given by Huguenin in the twelfth volume of Ziemssen's "Cyclopædia," the English edition of which has been duly reviewed in *The Doctor*. There we find a series of divisions of the pathological appearances, some of which might have been studied to advantage in reference to the defence in the Penge case.

The development of symptoms is usually said to follow a definite order, and authors often speak of the three stages—1, brain irritation; 2, pressure; 3, paralysis. In a typical case this order may be followed; but typical cases are rare, and moreover the disease is insidious in its attack, and not always watched throughout. There are many other difficulties. Cases are, in our own experience, apt to be very obscure, and we may state on the authority of Huguenin, that "*miliary tubercles may be developed in the pia mater without a single symptom during life leading us to suspect their existence.*"

Those whose attention has been roused by the Penge case to renewed interest in this disease would do well to reconsider it from the point of view which preceded that case. They will then be prepared to more critically consider the state

ments that have been published about it, and which we must proceed to collate.

In the report of the *post-mortem* in the Penge case it was stated that adhesions of the membranes were found, and also adhesion of the pia and brain. These were attributed to previous inflammation, and it was remarked that no appearance of recent inflammation, such as lymph or effusion into the ventricles, was present. "There were some small patches of rough millet-seed like deposit in the meshes of the pia mater, probably tubercular." This description, together with the symptoms observed at the close of life, laid the foundation for the defence, and there can be no question that the opinion of Drs. Bristowe and Payne, that they pointed certainly to death from tubercular meningitis, gave rise to the subsequent action. Dr. Greenfield, who could not give his evidence in court, has since published some important remarks on the case in the *Lancet*, and to his paper we shall now turn, merely observing that Mr. Wilkinson denies in the same journal the existence of adhesion.

Dr. Greenfield cites the symptoms observed during life—drowsiness passing rapidly into coma, with stertorous breathing, rigidity of one arm, and extreme inequality of pupils—as pointing to cerebral disease. He adds that "the presence of miliary tubercle in the pia mater, even if in small amount, as seen with the naked eye, is itself a sign of very serious cerebral disease," and that "it is never found after death in cases which have not presented cerebral symptoms during life." In support of this last statement he refers to Bristowe, Murchison, Payne, Wilks, and Moxon, but although he afterwards quotes Huguenin he does not seem to have noticed the remarkable passage we have cited above in italics. He says:—

"In the rarer form of tubercular meningitis, in which the tubercle exists *only* on the convexity of the brain, there is an absence of lymph exudation at the base, and of hydrocephalus; and there *may be* an absence of exudation on the convexity, and of softening of the brain-substance; a condition of extreme engorgement of the superficial veins, of general intense reddening of the pia mater, and a very vascular condition of the subjacent cortex, with more or less of the white matter, being the only sign of early inflammation visible with the naked eye. This also rests on my own observations, and the statements of authority (Huguenin and Gee).

"In this form ('tubercular meningitis of the convexity') death is usually much more rapid than in the commoner form (Gee). Even in the common form the amount of hydrocephalus and of brain-softening is very highly variable, and their amount bears no definite proportion to the severity of symptoms or rapidity of course. When chronic brain disease exists the changes in the brain and

the symptoms are often greatly modified (Huguenin).

"The onset of tubercular meningitis in the adult is often much more sudden and unexpected than in the child, and, in my experience, the disease is more rapidly fatal, in some cases only from twenty-four to thirty-six hours elapsing between the definition of the disease and death.

"The symptoms of tubercular meningitis, pre-
tean even in the child, are far more so in the adult, in whom they may simulate almost any form of cerebral disease. Drowsiness passing into coma may be the only symptom observed (Bristowe). Precise distinction between the symptoms of meningitis of the convexity and of the base is not possible in all cases. In some cases of the former the symptoms closely resemble those of meningeal hæmorrhage."

After this passage, which we have given textually, Dr. Greenfield examines the several symptoms presented in the Penge case at considerable length. It is unnecessary for us to follow him through these details, as they concern other points in the case. At present we are occupied with tubercular meningitis, and of this disease Dr. Southey (*Brit. Med. Journ.*, October 20, and 27) relates several cases which aptly illustrate some of its aspects. He had previously collected a considerable number with reference to some points of statistics. He finds that "the disease, as we advance in life, is less frequent, and the symptoms are far less distinct than in childhood. In adults the disease begins and pursues its fatal course with singular insidiousness, and is frequently misunderstood, even by experienced medical men until the autopsy reveals its true nature." This opinion, it will be observed, exactly coincides with that we have above expressed, and corroborates the statement of Huguenin.

Some of these cases very aptly illustrate the difficulty of diagnosis (one was received as typhoid), the general secondary nature of the meningeal disease, and other important points. In one most interesting case the true diagnosis was announced in spite of some spots thought to be possibly typhoid, founded on vomiting, headache, nape-pain, prior spinal disease, suspected to be strumous; temperature 101.6 in the evening, and 100.8 in the morning; no symptoms of typhoid except continued fever and delirium at night, and no pneumonia. There is much in the manner of such patients, the attitude, and other circumstances to suggest cerebral mischief, and, so far as description goes, this seems to have been the case here, and there was the prior spinal disease. This would suggest struma, which, as all will remember, is the most fruitful source of tubercular meningitis.

—*The Doctor.*

RECENT CASES OF PARACENTESIS
THORACIS.

Dr. George H. Evans (Clinical Society of London), read notes of three cases of pleural effusion which had recently been under his care, in which he had performed paracentesis thoracis, and which cases seemed to illustrate some of the advantages of that operation. 1. A groom, aged 23, was admitted into Middlesex Hospital on April 24th, 1877. His previous health had been good. Three weeks before admission he caught cold; sixteen days before admission, he had felt pain in the right side of his chest, and had become short of breath. On admission his temperature was 101.6 deg.; the respirations were 36. The right pleural sac was obviously full of fluid. On April 26th, paracentesis was performed with Coxeter's aspirating syringe, and seventy-two ounces of clear serum were removed. He improved rapidly in health, and was discharged recovered on May 18th. 2. A saddler, aged 29, was admitted on September 6th, 1877. He had caught cold in November, 1876, was then in bed for four months, and had not since been fit for work. On admission his temperature was 98.2 deg.; the respirations were 20. The right lung was healthy; the left pleural sac was full of fluid. On September 7th, he was punctured with Coxeter's syringe (the syphon action only being used), and thirty-five ounces of rather cloudy serum were removed. Fat globules were found under the microscope in the fluid. He progressed rapidly to health, and was discharged convalescent on September 26th. 3. A porter, aged 32, of previous good health, was admitted on May 24th, 1877. His illness had commenced in December, 1876, with pain on the left side. On admission, the left pleural sac was full of fluid, which had probably occupied it for some months. Temperature 98.5 deg.; respirations 32. He was tapped on May 16th, in the seventh interspace (Coxeter's aspirating syringe), but only fifteen ounces of serum were removed. On June 9th, he was again tapped in the next interspace above, and fifty-five ounces of clear serum escaped. He then gradually improved in condition, and seemed to be doing well, when Dr. Evans ceased attending the hospital at the end of June. On July 24th he was discharged relieved, and made an out-patient. On Dr. Evans's return the man was attending as an out-patient; and on August 15th his left chest was found to be fuller than before. Being re-admitted on August 16th, he was tapped on the 17th, and fifty-five ounces of serum were removed, with immediate improvement in the condition of his chest. He gradually improved in health and condition, with occasional suspicious signs at the upper part of the overworked right lung, which, however, had all disappeared, so that he was now convalescent, and rapidly gaining health and weight. Dr. Evans re-

marked that, having been for some years a strong advocate and admirer of the operation, he had been surprised to hear of and to read lately observations of much older and more experienced physicians rather in disfavour of the operation than otherwise. Of course he must admit that, in many cases of effusion of serum into a pleural sac, the fluid disappeared without being artificially removed; but he believed that nobody would deny that this process involved usually a considerable amount of time, during which almost absolute rest was a necessary part of the treatment. Now he could not see why one should not considerably shorten this interval by an operation of a very simple and, as far as he had been able to ascertain, harmless description. He believed that the old doctrine suggesting that the admission of air into the cavity during or after the operation would probably lead to the serous effusion becoming purulent was now exploded. At all events, he had never seen or heard of such a case, though he knew of certainly one and probably two cases in which the delay or neglect of paracentesis had been followed by a change from serum to pus, indicated in the one case, which he had followed throughout, by a rigor and afterwards a constant hectic temperature. As to the advantage of shortening the period during which fluid remained in the chest, one of the cases, No. 2 afforded an instance. The day before he was seen by Dr. Evans, he had, by the advice of his medical attendant, consulted an eminent hospital physician, whose advice was to the effect that he should rest for a month and then see him again, with the view of some action being taken in case the chest should be still occupied by fluid. Owing to the advice of a friend whom he met in the street, he came as an out-patient to the Middlesex Hospital, where, being admitted, he was at once tapped, and in three weeks afterwards sent out in good health.

Dr. Cayley referred to the frequent occurrence of tubercle in cases of hydrothorax, the tubercle developing in the lung the pleura of which had not been attacked by the inflammation. He considered the cause of this to be the protracted hyperæmia, and that an early removal of the fluid by lessening the hyperæmia would likewise lessen the chance of tuberculosis.

Dr. Williams referred to the advantage of early aspiration, and said he had never seen evil results from the operation.

Dr. Southey said the profession would greet any explanation of symptoms by which a line might be drawn so as to at once determine in what cases of serous effusion the fluid should be evacuated. Often fluid was absorbed in a few days, and surgery in such cases the operation was unnecessary. He would not advise tapping of the chest unless the effusion had remained long in a chronic state; should the disease be still active, not unless

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the fever was increasing, the tension severe, the urine very small in quantity. He then preferred the insertion of a trocar with an india-rubber tube attached, one end of which was under water, by which means no organ would be enabled to rid itself of the tension without the danger attendant upon the removal of excess of the fluid.

Dr. Jas. Pollock waited a month in chronic hydrothorax before proceeding to operate. He then preferred the elastic tubes to the aspirator.—*The Doctor.*

INTESTINAL OBSTRUCTION, ENTEROTOMY.

BY W. S. GREENFIELD, M.D., ST. THOMAS'S HOSPITAL.

The treatment of intestinal obstruction by the operation of opening the abdomen, searching for the cause of obstruction, and if possible relieving it, has as yet been tried in so few cases that its value as a remedial measure cannot yet be determined. The gravity of the operation, the uncertainty which must always exist both as to the exact nature and seat of the obstruction, and more than all the doubtful issue even if the obstruction be found and relieved, usually prevent the physician from counseling, and the surgeon from performing the operation until the patient is *in extremis*. In the present state of our experience it seems to be a duty to place on record all cases, whether successful or not which may throw any light upon the subject, or serve as a warning in future cases. The present case is an example of the dangers of delay, however short, when the diagnosis has become tolerably clear. It shows, too, how readily an otherwise fatal strangulation may be relieved by operation.

The patient, a man of about 60 years of age, was admitted to St. Thomas's Hospital, under my care (in the absence of Dr. Murchison), on August 5th, 1877. But little information was gathered as to his previous history, and that little did not throw much light upon the case. He was married, had eight children, and gained his living as a street musician. Up to the time of his attack he had enjoyed fair health, though not strong; and he had never suffered from any similar symptoms previously.

On the night of Tuesday, July 31st, he went to bed in his usual health, but woke at 2 A.M. on August 1st with severe pain round the navel, more especially towards the left side. This pain, as he described it, was not of simple colicky nature, but was severe, occupying a limited area, and distinctly localized in a region just to the left of, and slightly above the umbilicus. In a very short time he began to vomit; the exact period could not be ascertained, but it was within an hour or less from the onset of the pain. This vomiting continued at

frequent intervals; was aggravated by food or drink, but occurred independently of it. The bowels were scarcely open at all before admission—no very exact information on this point could be gathered from the patient; but it is probable that they were open once or twice slightly. The little fluid which he took consisted chiefly of milk and limewater. His wife noticed that he passed very little water from the time of being taken ill. These symptoms persisted with but little change during the four days which preceded his admission, the principal alteration being that the pain considerably abated, though it did not entirely cease.

He was admitted at 11 A.M., on Sunday, August 5th, and I saw him at about 12 30 noon. Pulse 90, regular—temp. 98°. Tongue clean, moist, pink. Vomits frequently, but in very small quantities (only a tablespoonful at a time), thin light brownish fluid, nearly clear, but with a few small brownish flocculi deposited on standing; colour very slightly offensive and sour, but not distinctly stercoraceous. The abdomen but little, if at all abnormal in appearance, neither obviously distended nor retracted; walls thin and flaccid. Respiration abdominal, but shallow. There was an entire absence of inequality due to distended coils of intestine, the surface was of the normal smoothness and uniformity. No tenderness on slight pressure at any point, nor for the most part on deep pressure or manipulation, but on firm pressure over a limited area to the left of and slightly above the level of the umbilicus the patient complains, and evidently suffers severe pain, which nearly ceased when the pressure is discontinued. In this position, too there is a certain feeling of slightly increased resistance, but no tumor can at any point be discovered. Abdomen generally resonant, perhaps at this point slightly less so, but with no marked difference in degree. No sign of hernia in the usual positions, no enlargement of glands in groin. The rectum was afterwards explored by Mr. Nicholson, the House Surgeon, who reported that there was no sign of cancerous growth.) An enema of olive oil had already been given and had brought away a small quantity of dark fluid feces.

I therefore ordered half a grain of opium, and one grain of extract of belladonna in pill every three hours, an enema, and iced beef tea and brandy in small quantities by the mouth.

Monday, August 9th, 11 A.M. Patient is decidedly more prostrate, vomits frequently, but in very small quantities, fluid of the same character as before, or of rather yellower colour. He appears slightly drowsy, pupils not all contracted; is said to have vomited all the pills immediately on taking them. Extremities colder and hands slightly blue; pulse more feeble, rapid, and small—about 108 per minute; temp. last night 99°, this morning 99°; tongue slightly dry; patient now lies down, does not sit up as yesterday. No urine

has been passed since admission, and there does not appear to be any in the bladder. Three enemata have been given but with no effect. The abdomen is now slightly fuller than yesterday, but entirely free from sign of distension, and no appearance of distended coils of intestine. Pain has now entirely ceased; but on pressure there is tenderness in exactly the same position as before. No other change in the physical signs, and no drawing up of knees. Reflex vermicular movements not too readily excited.

At 3 P. M. Dr. Bristowe kindly saw the patient, and advised an operation. Ether having been given, a median incision was rapidly made through the abdominal wall, nearly three inches in length, the umbilicus being in the centre of it. After dividing the peritoneum on a director, a coil of distended small intestine came into view; this was traced downwards, and a constricting band almost immediately discovered a little to the left, and below the umbilicus, apparently connected with the mesentery. I easily tore this through with the finger, and a strangulated loop of gut, with the seat of constriction deeply marked on its surface very dark purple in colour, but of glistening surface appeared in the wound. The intestine did not protrude, there was no difficulty in the operation, and the seat of constriction was discovered without delay. So far as the surgical procedure was concerned, its aim was most speedily and successfully accomplished, but the patient died before he could be removed from the operating table. Artificial respiration and intravenous injections with other restorative measures were tried for some time but without effect.

A *post mortem* examination was made at 9 A. M. August 7th, ten hours after death, by Mr. Mac Cormac and myself. On opening the abdomen the upper part was seen to be occupied by slightly distended coils of small intestine, the omentum being slightly drawn up to the right side. Occupying a position just below and to the left of the umbilicus an intensely congested loop of small intestine, which, when unfolded, and separated from the mesentery measured about six inches. At either end of this loop was an obliquely transverse pale line the mark of the constriction. The strangulated loop was of dark purple colour, from intense congestion, but not yet sloughing, it felt thickened, firm and fleshy compared with the rest of the bowel. The corresponding portion of the mesentery was also intensely engorged, and there were ecchymotic patches in other parts of mesentery adjacent. On close inspection very slight incipient peritonitis was seen in the neighbourhood only of the strangulation. The peritoneal cavity contained about 2 ounces of port-wine-coloured fluid. The small intestine below the seat of strangulation was contracted and empty, but not tightly contracted or notably pale; that above was dis-

tended and filled (as also the stomach) with thin peasy fluid of ordinary stercoraceous character.

On very careful search no sign of the constricting band could be discovered. Some portions of the omentum looked thickened and pinkish, and as if torn across, but no other condition could be found to give rise to the strangulation. On removal and opening of the bowels the upper extremity of the strictured portion was found to be exactly six feet from the pylorus. The whole of the tissues of the strangulated loop were intensely gorged with blood the valvæ conniventes especially engorged, and presenting some superficial erosion of the mucous membrane, forming yellowish-white lines.

The case illustrates very forcibly the importance of operating as early as possible when the nature of the case is decided or probable. But since in all such cases the diagnosis both of the nature and seat of the obstruction are of the highest importance, I may briefly discuss the grounds on which the diagnosis was based.

Pain.—It is well known that the pain in intestinal obstruction if the obstruction be at all acute, is usually referred to the umbilical region whatever the seat of the lesion. But here we had to do not with an ordinary pain, but with distinctly localised pain, increased on pressure, and made to recur by pressure after it had nearly gone. The position of this pain, and of the apparent slight swelling which accompanied it, rendered it probable that neither the lower part of the ileum nor the ileo-cæcal valve were involved.

Vomiting.—The early occurrence of vomiting is related perhaps rather to the suddenness and severity of the obstruction than to its position. But other things being equal, early and severe vomiting is more likely to occur when the obstruction is situated high up than when low down. But of perhaps greater importance is the fact that the vomit became very scanty even before admission, and that its characters were not those usually observed when the lower part of the small intestine is the seat of obstruction; and that supposing the strangulation to have been severe enough to cause so early vomiting, the other symptoms would by that time have been much more severe.

Suppression of Urine has often been regarded, since Dr. Barlow first drew attention to it, as a sign of the high position of the obstruction. The view which is now more commonly advocated, and which is endorsed by Dr. Bristowe in his article in Reynolds' "System of Medicine," is that suppression of urine is rather a sign of severe and sudden obstruction. It would therefore be presumptuous in me to offer any opinion against such distinguished authority; but I must confess to a bias towards the belief in the accuracy of Dr. Barlow's observations whatever explanation may be given of the facts. Thus much I may add, that I have never seen either in strangulated hernia or in intestinal ob-

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struction, so complete a suppression of urine as in the present case, nor have I ever seen an obstruction so high up in the bowel. It has appeared to me that whilst suppression or retention for twenty-four to forty-eight hours is not uncommon when the obstruction is low down in the small intestine or in the cæcum, sigmoid flexure or rectum there is very rarely any actual suppression for so long or at so late a period as in the present case.

But by far the most valuable and decisive indication of the high position of the obstruction was the almost entire absence of general swelling of the abdomen and of visible distension of coils of intestine. This was indeed so remarkable that doubts were expressed by good and competent observers as to the reality of the obstruction, they were inclined to consider that the vomiting was due to colic or some other cause when the patient was admitted.—*The Practitioner*.

SYME'S AMPUTATION AT THE ANKLE-JOINT.

BY E. D. HUDSON, M.D., NEW YORK.

The amputation at the ankle-joint (tibio-tarsal) originated by Mr. Syme is one of the triumphant achievements of the art of surgery for the cause of humanity. It is an operation which perfects the surgery of the inferior extremity, and one which is free from the disadvantages and defects pertaining to nearly all amputations of the foot and leg. The history of this amputation (Syme's) during the past twenty-five years, as performed by scientific and expert surgeons, affords conclusive evidence of its advantage to the patient, and demonstrates its superiority in conducting to comfort and usefulness to every other amputation of the foot or leg. It is the least disabling, the least incapacitating, and with scientific prosthetic apparatus the patient scarcely realizes any loss of limb. The end of the stump is painless and an enduring basis of support, reliable for any degree of pressure and service, and equivalent in conditions and functions to the heel of the unamputated foot.

The merits of a well-performed Syme's amputation can not be exaggerated. The subject of this operation simulates the whole more perfectly than the subject of any other. I am able to sustain this assertion by tabulated records of two hundred cases, of which I have personal notes.

My first observation of ankle-joint amputations, and experience in adapting apparatus thereto, was in the year 1853. I was requested by Dr. J. M. Carnochan, Surgeon-in-Chief of the New York State Emigrant Hospital, to give my attention to the first case of ankle-joint amputation performed in this

country by the doctor upon one of the hospital patients. Dr. Carnochan had but recently returned from Edinburgh, where he had been a pupil of Mr. Syme, and had become acquainted with his improved amputation at the ankle-joint and his mode of performing it. I examined the case with prejudice and as a critic, regarding it a bold and doubtful innovation, a departure from the best authorities on surgical practice; but the anatomical construction of the stump, its pathological condition, and its capacities for future usefulness with suitable prosthetic apparatus, impressed me most favourably. The immediate and the permanent results of that first case were all that could be desired.

In 1854 Dr. Stephen Smith, Surgeon to Bellevue Hospital, performed the second operation in this country of Syme's amputation at the ankle-joint on a girl at the hospital. I was present by invitation. It was a marked success; an honor to the surgeon and an inestimable benefit to the patient. She subsequently acted as a nurse in the wards, and was suspected by but few to be the subject of an amputation. This was the famous Kate Riley case reported in the *New York Medical Journal* at that time. Her walk and appearance in every respect were natural, and she experienced neither pain nor unusual fatigue. The most hostile and skeptical were silenced.

These two cases of operation at the ankle, and the successful and modified amputations at the knee-joint as revived and performed by Dr. Markoe, eradicated my prejudice against joint-amputations. The only deductions from the facts and cases presented were that the operation was *sufficient*; that it should be performed whenever the circumstances would permit; that it should be the preference of the surgeon in every instance of amputation of the lower extremity when he has the choice of site, whether a favourable or unfavourable condition of the tissues supplying the flap covering the end of the stump existed.

Every day's observation and experience during the period of twenty-four years has confirmed my judgment of the wisdom and benefits of the Syme amputation, as demonstrated by the subjects. Of some two hundred cases of tibio-tarsal amputation after Mr. Syme's method, or as modified by retaining the articular surface of the tibia, with which I have been concerned in consultations, operations, and ultimate reparative treatment with compensative prosthetic apparatus, all, without an exception, have resulted either immediately or remotely an entire success. Some few, either by reason of the extent of disease, injury, or shock, or other events to which surgical cases are exposed, underwent sloughing and healed by secondary intention, but in the end invariably yielded good stumps and solid bases of support. They were free from any degree of irritability, tenderness, abrasion, or ulceration, and proved eminently more serviceable than would

the same number of cases of ordinary amputation of the foot or leg. . . .

The invariable utility of the Syme stumps has demonstrated the physiological capacity of the base of support which it gives for any amount of service and weight. A gentleman suffering gunshot injury of the foot, and undergoing Syme's amputation at the hands of Pr. f. W. H. Van Buren, has repeatedly walked thirty miles continuously, upon gunning excursions, without his companions suspecting the defect in his limb. One of the earliest subjects of Mr. Syme's amputation visited me, sixteen years after the operation, for reparative apparatus, and reported his stump at all times serviceable and reliable. He, too, had travelled as far as thirty miles in one day, with the aid of a leather appliance, the "bucket," or shoe.

A Scotchman who had undergone a double Syme's amputation by Mr. Lister, of Edinburgh, in 1859, for comminuted fracture of both feet, emigrated to this country in 1869, and visited me for apparatus. With only leather buckets or cups for his stumps, and a cane with which to balance himself, he had subjected his stumps to duly hard usage. Finally, with the appropriate apparatus constructed to represent the functions of the foot, his walk was easy and stable without the use of a cane, and he has ever since been actively engaged in agriculture. . .

No amputation of the leg or foot should be substituted for the Syme when it is admissible, *save that of Lisfranc*. No improvement upon the Syme method can be made by any complex mode of operating, as the section of the cancellated structure of the end of the tibia and of the calcaneum for union thereto. I have had much experience with stumps so constituted—method of Pirogoff. Some of them have been well formed, and were far more serviceable than the stump of any leg-amputation; but where any considerable portion of the calcaneum has been annexed they have proved uncouth in form resembling a horse's foot, and afford comparatively a poor and painful base of support. Some have resulted in a false joint, and retraction of the appended part; others in necrosis of the continuity of the tibia above the annexed portion of the bisected os calcis.

The plea is often made that the increased length of stump produced by the appended portion of bone affords a superior advantage *to the poor man*; a false plea however, and better suited to medieval surgery. If for the poor man the bucket arrangement is alone available, an elastic wool felt pad, half or five eighths of an inch thick, in the bucket will be amply sufficient to offset any advantages afforded by the appended calcaneum, and the patient with the Syme stump obtains a more even and reliable base of support. As an alternative to the methods of Chopart, Pirogoff, or Quimby's modification, or a leg amputation with periosteal covering of the end of the stump, a large experience and ex-

tensive critical observation convince me that the *tibio-tarsal*, or Syme's method, is the most useful and worthy.—*Louisville Med. Times*.

ON RUPTURE OF THE MEMBRANES IN LABOR.

Dr. William Stevenson, Professor of Midwifery in the University of Aberdeen, in an article in the *British Medical Journal*, proceeds to discuss the diagnosis of the conditions which warrant us in having recourse to rupture of the membranes before the full dilatation of the os. The first point is the determination of the degree of expansion of the lower uterine segment. We have seen the size of the external os is no criterion of expansion. The os, in fact, may be very small, and yet expansion may be complete. It is by the internal os that we can best judge; but this is hard to reach, and difficult to determine its exact site. There is one means, however, of ready access, whereby we can form a proximate opinion; it is the degree of dilatation or updrawing of the vaginal cul-de-sac. This is a point which has been entirely left out in the consideration of the progress of the first stage. It is a matter of common experience to find, in the class of cases where we feel something is required to promote a labour with tardy dilatation of the os, that the upper part of the vagina is well expanded and drawn up, greatly increasing the perceptible diaphragm of the cervix, which alone obstructs the continuity of the developed canal. Now, we know that the longitudinal muscular fibres of the vagina run upward, and are continuous with those of the body of the uterus, and that the attachments of the uterus in their upper portion correspond with the internal os. This portion, then, can not undergo expansion without carrying with it the tissues which are in connection therewith. Consequently we find that as the first stage of labour advances the upper part of the vagina is dilated until it seems to coincide pretty closely with the upper part of the bony canal. When, therefore, a considerable portion of the lower segment of the uterus can be felt in the vagina, and not merely through its walls, expansion is certain to be complete, whatever may be the size of the parturient ring; and the tissue composing it are those of the cervix proper, and not the uterus. Under such circumstances I believe the membranes may be ruptured with advantage. It is, however, unnecessary in many cases to wait for the full development of the condition above described. I have taken the extreme state, as being most readily understood, and indicating the direction in which our observations should be made.

Another class of cases, or it may be only an additional character to those of the first, are where the action of the uterus seems to be effecting not steady

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dilatation, but extreme thinning of the tissue of the cervix; and also where the head is felt to be in close contact with the parturient ring, there being little or no bag of waters.

The next point to be considered is the quantity of liquor amnii; not the actual quantity, as is generally referred to, when speaking of its being present in excess, but the proportion its amount bears to the size of the child, and also to the capacity of the amniotic sac. This latter is rarely quite filled; otherwise it would remain much more tense than it usually does in the intervals between the pains. If it be nearly or entirely distended, it will interfere with the power of restitution of form, by preventing alteration in the form of the uterus, and consequent action on the fetus, even though the actual quantity of waters is not greater than ordinary. In this circumstance it must be regarded as really in excess, quite as much as where there is excess in actual quantity. Undue tension, therefore, of the membranes during a relaxed state of the uterus must be regarded as unfavorable to the mechanism of labor, and as warranting an earlier rupture of the membranes than under other circumstances.—*Philadelphia Reporter*.

ASTHMA NERVOSUM, SUCCESSFULLY TREATED WITH ARSENIC-INHALATIONS AND GALVANISATION OF THE VAGUS NERVES.*

Within the last six years, seven cases of nervous asthma have come under my observation, and I believe them to be of sufficient interest to be recorded as illustrations of an obstinate and distressing disorder of a true nervous nature having been speedily relieved and permanently arrested by electricity and arsenic-inhalations.

CASE I.—W. M., of Prestwich, near Manchester, consulted me on October 26th, 1871. His age he stated to be twenty-three; he has enjoyed a liberal education and good living, his parents being wealthy merchants in the city. At fourteen, he had pneumonia, and since that time, now nine years, he was subject to frequent attacks of asthma. Lately, he had them every night. They generally came on him suddenly in the evening before bedtime, and lasted through the greater part of the night. The attacks commenced with a sudden feeling of suffocation, want of air, and great anxiety; and ended with coughing and sneezing, and with more or less of thick mucous discharge coming out through the mouth and nose. In daytime and in the interval between the attacks, he felt quite well, and his breathing was free and easy.

* Read by Dr. Wähltuch before the Medical Section at the annual meeting of the British Medical Association in Manchester, August, 1877.

He had tried various drugs, chiefly narcotics and antispasmodics, but without any good effect. He had frequently changed his residence; travelled and spent some time in France, Germany, Portugal, Italy, Switzerland; but nowhere felt benefited. At Heidelberg, he experienced some relief from the use of compressed air in the pneumatic chamber, and also felt better during a twelve months' stay at Lisbon. Whenever he returned home, the attacks came on in a more aggravated form,

My plan of treatment was the following. At first, I ordered a large dose of muriate of quinine (ten grains) to be taken every evening before the expected attack, which periodically reappeared at the same hour before bed-time. The result was a later outbreak of the attack, which awoke him after a few hours of sound sleep. I then ordered spray-inhalations of arsenic twice a day, and in gradually increasing doses, changing now and then the preparations. The following were used in succession: Arseniate of soda (one-sixth to one-half grain); arseniate of potash (Fowler's solution, half a drachm to a drachm); arseniate of ammonia (one-quarter to one-half). To the inhalation, I at first added tincture of datura tatula, but soon had to leave it out, as it produced symptoms of narcotic poisoning. The arsenic-inhalations were administered during the first two months twice a day; the third month, once a day; the fourth month, three times a week; the fifth month, twice a week; and after the fifth month, the inhalations were entirely discontinued. Considering my patient's disease to be of a nervous character, and believing the pneumogastric nerve to be the chief actor, I decided from the first to try also the effects of galvanisation. I selected the continuous current derived from Althaus' battery, with fifty small Smee's cells, of which I used at first five, and gradually and carefully increased to thirty cells. A wet sponge, dipped in tepid salt-water, and connected with either of the electrodes, was applied to the skin of the neck; that connected with the positive pole I put to the submaxillary fossa, along the inner edge of the sterno-cleido-mastoid muscle; and the other sponge, connected with the negative pole, I placed close to the trachea and near the sterno-clavicular articulation. I galvanized each nervus vagus separately from two to five minutes. Galvanisation was applied daily for six months.

The attacks at first changed the hour; instead of 7 P.M., they awoke him every day at 4 A.M., but were of a milder character. The attacks returned nightly from October 26th to November 3rd; then again, November 7th, 18th, 20th, 21st, and 25th; December 3rd, 15th, and 20th; and lastly, January 17th, 1872. He continued the treatment till May, 1872, but had no more attacks since January 17th 1872; and continues free from any asthmatic symptoms to this day, for more than five years and a half. He is actively engaged in business in

Manchester, and frequently travels on the continent; but continues to enjoy very good health in all seasons and climes. I am, therefore, justified in considering him permanently cured, and believe the chief remedial agents to have been the use of galvanism and arsenic-inhalations.

CASE II.—T. W. K., of Bowdon, Cheshire, consulted me September 4th, 1872. He was engaged in the Manchester trade, and twenty-five years old. When a child, he frequently had croupous attacks. When fifteen, he had gastric fever, and subsequently pneumonia. Three years ago, he had slight pleuropneumonia, and since that time he had suffered from frequent attacks of dry nervous asthma. The attacks occurred at all times, but chiefly in the night. Crowded rooms, sea or mountain-residence, any change of air, would bring on an attack. In the intervals, his breathing was free and easy, and he had no cough. After the attacks, he expectorated thick mucous discharge. His chest was broadly built; respiration was audible and clear all over the thorax; the percussion sound was normal; the cardiac sounds were clear; the uvula and epiglottis were large, but of a healthy appearance.

I ordered arseniate of soda inhalations, and applied daily the continuous current to both nervi vagi, in a similar manner to that described in the first case. The treatment continued during a month, he having had only one mild attack in the beginning. I saw him lately, and he told me that he had no attacks during nearly five years since I attended him.

CASE V.—Miss E. H., of Bowdon, Cheshire, aged 42, has been under my observation since June, 1876. She suffered for eight years from severe attacks of nervous asthma, and is also subject to bronchial catarrh. She used to have frequently abscesses in the lower part of her back, but had none since August, 1875. Has had ulcerated tonsils eighteen months ago. The asthmatic attacks came suddenly in her sleep, generally between 2:30 and 6 A.M.; but any exertion or a rich supper would bring them on. She has frequently pains in the back of her head and neck. Menses regular. Appetite moderate. Bowels sluggish. I saw her both during the attack and also in the intervals. Dry whistling râles could be heard everywhere during an attack; but in the interval, although the breathing was free and easy, moist râles were audible in the scapular region of the thorax. The attacks resembled those described in my other cases.

The treatment consisted in galvanisation of the nervi vagi, and in spray-inhalations, chiefly of arsenic, and also of various additions at different times, such as chloride of ammonium, tincture of datura tatula, ozonised sea-salt, salicylic acid, and cherry laurel-water. She had attacks June 30th, July 11th and 13th, September 15th, December

4th, 1876, and the last time, January 17th, 1877. She also had two attacks of acute bronchial catarrh in September, 1876, and February, 1877, which I treated with Iceland-moss poultices applied to the whole thorax, and the internal administration of expectorants with belladonna; stopping inhalations and galvanisation during the bronchial affection. She is at present in a much better state of health than for years, and no spasmodic attack since January last.

REMARKS.—The treatment of nervous asthma by galvanisation of the pneumogastric nerves, and also by spray-inhalations of arsenic, seem to me to be very efficient, as, of seven cases under my observation, five were permanently cured and two greatly benefited. Four of my patients suffered from nervous asthma only, and three had, in addition, bronchial catarrh. One case was also hereditary, her father and sister being subject to asthma nervosum.

Galvanisation has been used with brilliant success for the treatment of two cases of true nervous asthma by Dr. Althaus (*Treatise on Medical Electricity*, second edition, London, 1870, page 522), also by Dr. Benedikt, of Vienna, in one case (*Electrotherapie*, Wien; 1868, page 309); and by Dr. Brunner, of Warsaw, in four cases lately published (*Sovremennja Medicina*, Warsaw, 1897, Nos. 1-4).

Successful cures of nervous asthma have been effected with arsenic-inhalations by Dr. Wistinghausen (*Petersburger Medicinische Zeitschrift*, 1862, page 137), and also by Dr. Lewin (*Inhalationstherapie*, Berlin, 1855, pp. 443-445).

I am of opinion that the two methods of treatment by galvanisation and inhalation may be safely combined, and ensure permanency in their beneficial effects.—*British Medical Journal*.

CONOID CERVIX, RESULTS AND TREATMENT.

The external os is the most usual seat of the constriction and obstruction in conoidal cervix. This arises from the peculiar pointing of the intra-vaginal cervix, together with an excessive development of the circular fibres.

The os internum is found constricted, however, in associated anteflexion. Such a malformation may have arisen, and ordinarily does in such instances, at the period of the second, the pubertal development of the uterus.

The first and most prominent symptom of the conoid cervix is dysmenorrhœa. From the nature of the malady, we would expect the pain to be characteristic, viz.: expulsive, bearing down, like labor-pains, preceding the flow, and diminishing as it ceases. Whether it is so or not will depend in part upon the quantity of the flow, and

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the extent of the obstruction. These symptoms are not altogether to be relied upon in determining the local condition, for they may resemble the neuralgic or congestive forms of dysmenorrhœa. Bearing in mind the secondary organic changes liable to ensue from obstructed menstruation, we naturally look for this sooner or later. It is doubtful whether a distinct variety of dysmenorrhœa in any of its forms, can exist for any length of time in its purity. One and then another variety is almost necessarily engrafted upon the original. Thus, for instance, obstructive dysmenorrhœa leads to congestive, and then to neuralgic.

Again, while menorrhagia is often a functional disorder of the uterus, resulting from obstruction, in time, after years of suffering, this function may be quite suspended, so short is its duration, so scant is the flow. Such a change, the effect of atrophy of either uterus or ovary, or both, means that there is no longer an obstruction, but worse still, the irreparable mischief has been done.

Considering the results which may follow in any given case of well-marked conoid cervix, really this malformation is a very grave one, not simply so far as the monthly pain is concerned, but also the denial of the procreative power of the patient, and still more, the serious inroads the local mischief may entail upon the whole general health.

Pain may not be limited to the menstrual time, but be constant from secondary complications, the chronic congestions and inflammations of the uterus and its appendages. Fatal retro-uterine hæmatocele or pelvic peritonitis may supervene.

Sterility, like dysmenorrhœa, is present in the vast majority of the cases of conoid cervix. These two functional disorders go hand in hand.

Of the vast number of causes of sterility in the female, perhaps there is no more common one than this under consideration. Fortunately, too, it is the most remediable, if of not too long duration, and if before secondary changes have occurred in the endometrium with chronic catarrh; or chronic ovaritis, with morbid or suspended ovulation; or finally, atrophy of either uterus or ovary. Not all of these changes are apt to ensue in a single case, but such is possible, if the obstruction is sufficient and the duration great. * * *

This operation is practiced by incising the cervical walls on either side from os internum through os externum. The incision is superficial above, but as it extends downward is gradually deepened. The fibrous tissue is not cut through and through, from out to out, in the infra-vaginal portion of the cervix as some have recommended, but the extent of the new opening at the base or os externum is about one-half inch. Allowance is thus given for contraction which necessarily follows in the process of cicatrization. In fact, care is to be taken that the subsequent contraction does not go too far, with a return of the parts to their old

faulty condition. To guard against this, the use of the vulcanite stem after the incision, or the occasional passage of the sound is needed. This operation has been a much abused one. While subject to great abuse, it is a very useful one in properly selected cases, and if properly performed.

Compared with dilatation by means of tents or expanding instruments, as dilators or bougies, it is infinitely superior. The result desired is more promptly attained in a less painful manner, and is vastly more permanent. Really, in cases of this kind, dilatation by tents, etc., should be discarded. The methods of Simpson and Sims consist in cutting the cervix through and through. Such procedure has a very strong tendency, it must be confessed, as shown by Peaslee, to destroy the natural tonicity of the cervix, deform the shape of the uterus, leaving an open, gaping os, an everted cervical canal, with chronic catarrh, a condition itself of things leading to sterility; or, if conception possibly does occur, one favorable for abortion. Besides, the danger of the operation is materially increased. The only recompense for the above evils is the relief to the dysmenorrhœa.

There is no better instrument for this operation than the knife of Sims, or one with a similar blade with fixed handle. I am in the habit of using the latter. All of the various metrotomes of *Greenhalgh, Routh, Simpson, and Atlee*, with shielded blades and worked by spring or screw, while they do credit to the originator and instrument maker for their ingenuity and workmanship, are costly, clumsy, uncertain in action and dangerous in practice. The dangers of the operation performed in the manner recommended, unless there are special contra-indications, are very slight. The results are gratifying, usually, as to the relief of the dysmenorrhœa. Sterility is not, however, by far so frequently overcome, though success covers no small per cent. Too often the secondary changes referred to have taken place in the cavity of the body of the womb, or in the ovaries themselves, barring relief to the sterility.—*Dr. Palmer, Clinic.*

TRAUMATIC NEURITIS INVOLVING THE BRACHIAL PLEXUS.

The following case, which was observed at the Hospital of the University of Pennsylvania, in the service of Professor H. C. Wood, is of considerable interest because of its severity, peculiar character, and the favourable result of treatment.

J. D., aged 32, two years before coming under observation, had his left arm caught in a belt and was carried several feet from the floor. The arm was broken about the wrist, the middle of the forearm, and near the shoulder. It was also badly twisted, and since the accident had been entirely

helpless. He could not move the arm, forearm, or hand in any direction. On attempting motion, pain and violent tremor would ensue. He carried the hand in a sling. The limb was somewhat wasted, but did not present the extreme atrophy which is noticed in some cases of spinal or nerve injury.

From an irregular line around the arm about two inches above the elbow, a district of highly-marked hyperæsthesia extended upward, including, when he was first seen, the outer part of the shoulder, and afterward spreading until it embraced the left breast, side, and back, in the scapular and supra-scapular regions. He had constantly considerable pain in the hyperæsthetic area, and touching or handling him gently would cause extreme suffering, and bring about fibrillary twitchings in the thoracic muscles. The pain and hyperæsthesia usually got much worse in the evening and during the night.

From the line of demarcation, two inches above the elbow downward, the limb was anæsthetic. Analgesia, or loss of the sensation of pain, seemed complete. Compass points could be jabbed into his forearm and hand with impunity; and to the same parts a strong faradic current could be applied without causing the patient any pain or inconvenience, unless the application was so made as to jar the entire limb. Electro-contraction was good. The skin was pale and smooth-looking.

The third and fourth dorsal vertebræ became tender to pressure while the case was under notice; and when at its worst, slight hyperæsthesia was present on the *right* side of the spinal column, in the scapular region.

This patient had been subject to epileptic seizures for twelve years. They were supposed to have originated from sunstroke. Since the accident to his arm they had been less frequent and less severe. He had never had any form of venereal disease.

The treatment pursued in this case has extended over nearly ten months, and will be briefly summarized. Bromide of potassium was given, mainly with the view of controlling the epileptic attacks. Iodide of potassium and the bichloride of mercury were administered for several weeks. At one period he was blistered over the dorsal vertebræ, and later the actual cautery was repeatedly applied. Morphia was sometimes used by the mouth or hypodermically. Galvanization of the hyperæsthetic district was employed. A weak current, usually from about five cells, was employed, applying one rheophore, generally the cathode, to the cervical spine, and the other to the affected region. The application nearly always relieved temporarily the pain and hyperæsthesia.

Six months after coming under treatment the patient was, on the whole, rather worse than when first seen, although he had several times temporarily

improved. He was then ordered to use by inunction upon the arm and shoulder about a drachm daily of a prescription containing equal parts of ointments of mercury, iodine, and belladonna. Four weeks after beginning this treatment the pain left his arm and side, the hyperæsthesia and anæsthesia also rapidly disappearing. He steadily improved, and has now, nearly three years after the accident, made a complete recovery from the neuritis. The motions of the shoulder, arm, forearm, and hand, have all returned, and under faradization the muscles are all rapidly regaining tone and strength. A few days after the improvement set in, his mouth began to show signs of mercurialization; but the inunction was continued until well-marked salivation was produced. Chlorate of potassium and cinchona were subsequently employed to relieve the pyalism.

Remarks.—In this remarkable case some of the great branches of the brachial plexus were probably severely injured, by torsion, tearing, or pressure, at the time of the accident. The neuritis which was set up seems to have radiated to nearly all the nerves of the plexus, as well as to other nerves, and involved, to a limited extent, the spinal cord. The neuritic process even appeared at one time to have extended across the spinal cord to the right side. The inflammatory condition of numerous nerves and their branches was doubtless the cause of the pain and hyperæsthesia, while the total anæsthesia below can be explained on the view of Niemeyer, that inflamed nerves are bad conductors, and hence convey peripheral impressions incompletely, or not at all, to the brain. Whether the cure was spontaneous, or the result of the treatment by inunction, the reader may judge for himself. For myself, I believe that it was in great part, at least, due to the treatment. According to Erb, the sovereign remedy for all the more chronic forms of neuritis is the galvanic current; and I have myself found it of great service, both as a palliative and curative agency. In the case just reported, galvanization with a weak current would relieve the pain and hyperæsthesia more effectually and for a longer time than any other remedy; but it was difficult to carry out the electric treatment with absolute regularity, and to include every portion of the wide neuritic area in each application.—*Dr. Mills, Medical Times, Philadelphia.*

VOMITING IN PREGNANCY SUCCESSFULLY TREATED WITH INGLUVIN (VENTRICULUS CALLOSUS GALLINACEUS).

I was called to see Mrs. S., aged 27 years, June 8, 1877, who stated that she was suffering from constant and excessive nausea, which was only relieved upon assuming the recumbent posture.

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This continued, gradually increasing from day to day, until in a week it eventuated in retching and emesis, during which watery matter with an acid taste, followed by bile, was ejected. This reached such an extent that the patient had hardly any freedom from it during the whole twenty-four hours, vomiting as often as twelve times a day.

Taking this in connection with the suppression of the menses, I concluded she was pregnant, and obtained from her the following history :

This was her third pregnancy. With the two preceding ones she suffered quite as much as with this, and, according to her statement, "had employed the services of several physicians, who administered almost every medicine in the pharmacopœia," but without avail, and she was obliged to lie in bed almost the entire nine months, in order to obtain relief from vomiting.

I proceeded to treat her in the orthodox way ; advised the administration of a gentle cathartic, gave carbonic-acid water freely, and prescribed the following :

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This was not followed by the slightest remission in the symptoms.

I then doubled the quantity in each powder ; this also failed.

I finally increased the subnitrate of bismuth to ʒi. doses every three hours, also highly spoken of. Various hygienic measures, as well as some other medicines, were resorted to, but all failed to bring about the desired relief.

About this time my attention was called to the preparation *ingluvin*, recommended in cases of this kind, and I determined to try it at once.

I prescribed *five grains* of Warner's *ingluvin* every two hours, and continued this for three or four days without any appreciable result other than diminishing the violence of the attacks of retching and vomiting.

I increased the dose to *ten grains* every two hours. This seemed to relieve my patient to such extent that she only vomited before meals, at the sight or smell of food.

I then increased the dose to seven grains, giving it half an hour before each meal. This soon had the desired effect of controlling the attacks. Continuing the same dose every three hours, the vomiting and nausea ceased entirely in four or five days.

She made a complete recovery in the second month of her pregnancy, in three weeks from the time she commenced the use of *ingluvin*.

ingluvin has certainly proved very efficacious in my hands, and I would therefore cordially recom-

mend it to the medical profession as worthy of a trial. I consider it an invaluable remedy in obstinate cases of vomiting in pregnancy.

I might also add that I have used *ingluvin* successfully in several cases of chronic dyspepsia, in which pepsin had failed.—(*Dr. Frowert, Medical Record.*)

WHEN NOT TO GIVE IRON.

In the current number of the *Practitioner* Dr. Milner Fothergill has contributed a few very practical remarks on the contra-indications for giving this drug. As long, he says, as there is rapidity of pulse combined with rise of temperature, so long must iron be withheld in the treatment of acute disease. As long, moreover, as the tongue is thickly coated, or red and irritable, it is as well to withhold chalybeates altogether. This is particularly true of phthisis ; no matter what the other indications are, it is useless, and sometimes worse than useless, to give it unless the tongue be clean without irritability.

It may be laid down as a general rule that this toleration of iron diminishes as the age increases. Young children take iron well, and it is often well borne by them in conditions which in the adult distinctly forbid its use.

There is one condition where iron is absolutely forbidden, and that is the condition known as biliousness. As long as there is a foul tongue, a bad taste in the mouth, and fullness of the liver with disturbances of the alimentary canal, iron is not only of no service, but positively does harm. Sir Joseph Fayrer's Indian experience is in full accord with this expression of opinion. In speaking of the treatment of hepatic congestion, accompanied by anæmia, he lays stress upon the resort to purgatives and vegetable tonics and the avoidance of iron, until the biliary congestion is removed. "When the portal circulation is relieved some preparation of iron may be useful."

When given in large doses iron always blackens the stools, but if given in moderate doses and well assimilated this blackening is not so marked. The colour of the stools, then, may be utilised as an indicator as to how far chalybeates are assimilated and are likely to be useful.

There are two different states found in women where iron is either totally contra-indicated or to be given with great caution. The first is a condition of amenorrhœa in florid, plethoric persons. The other is the opposite condition of menorrhagia in certain females. There are cases of menorrhagia associated with pallor and debility, where the usual compound of iron and extract of ergot is not so useful as a non-chalybeate treatment. In these cases it is not any imperfection in the process of blood manufacture which is to be remedied, for the blood

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is made rapidly and quickly, only to be lost at each menstrual period. It is here desirable rather to limit the rapidity of the blood formation, so that when the severe vascular turgescence of the menstrual period comes, it will not find the blood vessels too distended with blood. This will lead to diminished catamenial loss, and so the blood waste will be economised. According to the experience of Dr. Brown Séquard and Dr. Hughlings Jackson, iron does not suit epileptics. It increases the tendency to fits. It may improve the general condition, but it aggravates the epilepsy.—*Med. Press and Circular.*

THE DESTRUCTION AND EXPULSION OF UTERINE FIBROIDS BY ERGOT.—Dr. William H. Byford, who contributed to Vol. 1. Gynæcological Trans., a report of three cases of uterine fibroid in which the administration of ergot resulted in their piecemeal expulsion, reports in the *archives of Clinical Surgery*, an additional case showing the great value of this agent. The patient was aged forty-seven, and had for three years been the subject of severe hemorrhage, leucorrhœa, pain in the uterus and general prostration. Examination revealed a large fibrous tumor of the uterus which extended to within two inches of the umbilicus, filling up the hypogastric region and extending to the ilium on the left side. The uterine cavity admitted the sound fully two inches. Dr. B. at once prescribed thirty drops of Squibbs fl. ext. of ergot three times daily, this dose gradually to be increased to one drachm. At first it had no perceptible effect; in a few days, however, the pain became so great that the medicine had to be omitted for several days at a time. It was resumed in smaller doses until the pain returned too severely, when it was again temporarily discontinued. She continued the medicine in this way until January 13th, 1877, when the tumor began to break up and be discharged. In a letter to Dr. B., the patient describes the appearance of the material discharged as "like sausage meat from a stuffer," four inches of which would be extruded and cut off daily by the patient. Its discharge was accompanied by sharp spasms of lancinating pains and an intolerable stench. On the 26th of January, the last portion was discharged, after which the patient soon regained perfect health. In commenting upon this case, the author remarked that "in the intramural tumor where the neoplasm is so situated that the greater portion of the muscular fibres surrounding it lies outside, the persistent use of ergot if it causes contraction will be very likely to cause its expulsion." The constant pressure on the fibres which lie on the inside, impairs their nutrition and soon results in rupture. With proper care in the examination of cases—with a view to determining the site of the tumour—the

cases in which ergot will result in their expulsion can be predicted with a reasonable degree of accuracy.—*Med. & Sur. Journal, Toledo.*

MULTILOCLAR OVARIAN CYST COMPLICATED BY PREGNANCY.—Erskine Mason (N. Y. Pathological Society,) presented the uterus of a patient upon whom ovariectomy had been performed. The interest of the case rested on the fact that there was a fetus in the uterus, as well as a large ovarian cyst filling the cavity of the abdomen. A number of similar cases had been recorded, including nine by Spencer Wells.

The patient was thirty years of age, single, and entered Roosevelt Hospital July 30, 1877. Eighteen months previously the abdomen began to increase in size, beginning on the left side. This enlargement was at first slow, but during the past two months the increase was so rapid as to cause marked dyspnoea. A vaginal examination showed the uterus to be high up in the pelvis, and movable. The abdomen had distinct fluctuation, with an area of flatness not changed by the position of the patient. The measurements were: From the anterior spinous process of the one side to that of the other, nineteen and a half inches. From the ensiform cartilage to either spinous process, ten inches. Circumference of the abdomen at the umbilicus, thirty-nine inches. Circumference of the abdomen at the spinous processes, thirty-eight and a half inches.

The patient was examined by one of the most expert ovariectomists in the city, and was considered as a favorable case for operation. Ovariectomy was accordingly performed, and, on opening the abdomen, the trocar was passed into one cyst, and eight ounces of fluid evacuated. This, unfortunately, proved to be a pregnant uterus, and as soon as the mistake was discovered the uterus was closed with sutures and the abdominal walls brought together. The patient passed a restless night, and gave birth to a fetus at the sixth month. Death occurred eighteen and a half hours after the operation. The autopsy revealed a large multilocular cyst of the left ovary. There was no blood in the cavity of the abdomen. The uterus was closely contracted. There were no evidences of peritonitis.

Dr. Sayre said that too much credit could not be given to Dr. Mason for the frank manner in which he described the unfortunate issue of the operation, and he was of the opinion that, if other surgeons were equally honest in reporting cases, many more would be on record for the benefit of the profession.

Dr. Janeway referred to nine cases which Spencer Wells reported, in which pregnancy was found at the time of operation.—*N. Y. Med. Journal.*

A CAUSE OF INFANT MORTALITY.—We lately recorded a case where we believed the death of an infant had resulted from careless and injudicious feeding. Some correspondence having followed

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the Journal in connection with the subject of feeding infants, we subjoin a few remarks on the general diet suitable for infants. If an infant under seven months be deprived of its mother's milk, hand-feeding of some kind must be resorted to, unless the services of a wet-nurse can be obtained. The most convenient method of administering food in such a case is by means of a feeding-bottle. The character and mode of preparation of the food have now to be considered. Up to the age of six months little or nothing should be given besides milk, fresh, warmed, sweetened, and diluted with one-third or fourth part of water or lime-water, the latter being preferable when there is any tendency to offensive and loose motions or vomiting; three or four ounces of the food being given every three or four hours or less, according to circumstances. But in all cases the time of feeding should be fixed and rigidly adhered to. In some cases baked flour, rusks, etc., may be given with advantage under six months: but with most children such a diet is but ill borne, causing gastro-intestinal irritation, as evidenced by vomiting, with loose and offensive motions. After the age of six months, and toward the time when teething may be expected to commence, other food may be added to the diet, such as one tablespoonful of baked flour, either home-prepared or in the form of Ridge's food. The heating renders the farinaceous food partially soluble. Fatty food may be given with advantage once a day, in the form of yolk of egg beaten up with milk, or mutton-suet melted in milk by gentle simmering, two ounces of suet being used to thicken one pint of milk. The mixture, being sweetened and strained, can be taken through a feeding-bottle. Important as is the subject of infants' diet, we must not dwell longer on the subject, but refer our inquirers to the suggestions given in Dr. West's work on the Diseases of Infancy, and in Dr. Eustace Smith's Clinical Studies of Diseases in Children, and in works by other authors. Referring once more to the case on which we commented, it appears that death resulted from injudicious feeding, the child being as truly starved to death as if all food had been withheld. We are at the same time well aware that some children, naturally of a strong digestion, may live and thrive on almost any food.—*Brit. Med. Jour.*

OPIUM FOR THE PHOTOPHOBIA OF SCROFULOUS CHILDREN.—Dr. F. Betz (*Memorbilien*, 7 Heft, 1877,) states that the application of opiates in this affection is practicable, and that the greater ease and exactitude of carrying it out would soon cause it to supersede the atropine treatment. It being impossible for us to always keep these cases directly under our charge, the following plan seemed to him the best to be adopted. He begins by ordering 5-6 drops of the tincture of opium to

children, two or three years of age, just before retiring; older children receiving corresponding doses. Besides this, a compress dipped in cold water, and folded 6-8 times, is so bound to the face as to cover the forehead and upper part of the face, extending at the same time well over both eyes. In very severe cases the compress may be dipped into ice-water. At any rate, the opiate is the principal feature, and the dose of this is gradually increased until quiet sleep is secured. Photophobic children are generally restless during their sleep, turning and crying out every few minutes. The opiate controls this symptom. The first local sign of improvement is that the children open their eyes earlier in the morning. The action of the opiate is often so prompt that a remarkable improvement is observed after a single administration, and now and then a complete disappearance of the photophobia after a few days' treatment. Other local applications often require treatment for a longer time. The great change in the disposition of the heretofore peevish and irritable child shows how much the pain produced by too bright a light affects the entire sensitive nervous system. To guard against relapses, Betz continues the evening dose of opium for a considerable period, and expresses the opinion that the general nutrition is improved thereby.—*Allgemeine Wiener Med. Zeitung.—Clinic.*

DYSPAREUNIA—VAGINISMUS.—Clinic by Prof. Thomas.—I present to you a case which, when you enter practice, will be of service in aiding you to treat a condition which cannot be considered as rare. A point of interest to the physician, as well as the patient, is that, with proper treatment, a complete cure may be effected; and unfortunately a similar prediction cannot be made in many gynecological cases. Out of regard to the feelings of the patient, I shall run over the history. She says that since her marriage any attempt at coition caused very severe pain, and moreover, any proposition to that effect gave rise to severe trepidation. When she was placed on the table, and the labia drawn, the hymen was found to be complete. The finger was then placed upon it, when the patient suffered severe pain, similar, as she says, to what was felt during the efforts at intercourse. There was noticed, also, a caruncle near the urethra. Dr. Burns, the Scotch obstetrician, long ago recognized the disease, and since that time may have contributed to the literature of the subject. It was, however, to Dr. Marion Sims that we are indebted for the first thorough description, with method of treatment. He called it vaginismus. It seems that there is a hyperæsthesia around the vulva, and the slightest pressure gives rise to severe pain. The operation is quite simple, and, as I remarked, offers an exceedingly satisfactory result. After the patient is anæsthetized, she is placed upon her

back, with the thighs separated as widely as possible. The assistants then draw apart the labia and expose the hymen. This is grasped by a forceps, and the whole of it removed by means of the scissors. Any hemorrhage is readily controlled by pressure or ligature.

The opening of the vulva is then further enlarged by several incisions carried downward and outward. The incisions in this manner radiate through the perineum. After all hemorrhage has ceased, the glass plug is inserted and retained in position by means of a strip of adhesive plaster, which passes from the sacrum across the vulva to the abdomen, anteriorly. This plug should be kept continually in position for the first fortnight, and after that time, it may be found that by introducing it at night the necessary dilatation will be kept up. After six weeks it may be dispensed with entirely, and it will then be found that the patient is cured. I remarked, when speaking of the examination of the patient, that a caruncle existed near the meatus urinarius. It can be removed, without difficulty, by the scissors.—*Medical and Surgical Reporter.*

DIET AND MEDICATION IN SACCHARINE DIABETES.—The best diet for a diabetic patient is, for breakfast, eggs, and any kind of meat except oysters, gluten bread, and tea or coffee with milk and without sugar; for dinner, tomatoes, lettuce, onions, spinach, string beans, meat, light sour wine, and lemons, or perhaps oranges, but none of the sweet fruits; supper, about the same as breakfast. None of the starchy foods, no alcohol, and no sugar should be allowed.

Among drugs, opium is the most valuable. Of this an immense amount can be taken daily without any of the symptoms of poisoning. I am giving a boy now under treatment for this disease seven grains of opium per diem. In this case the only bad effect has been the production of obstinate constipation. I have known of cases where even this was unnoticed. The opium directly, by diminishing all the secretions, or more probably by its action on the nerve centres, relieves the excessive thirst and voracious appetite, and reduces the amount of urine and of sugar in the urine. In the present case the daily amount of urine has been reduced from twenty eight to eleven pints, and the total amount of sugar has been reduced proportionately. Ergot, which acts in simple diuresis almost like a specific, may be used in saccharine diabetes with much profit in doses of one drachm of the fluid extract four times a day. Where the skin is dry and rough, as in the present instance, jaborandi is of value by reason of its great powers of diaphoresis. If jaborandi be used the ergot and opium must be stopped for the time being.—Dr. Pepper, *Clinic.*

CROUP TREATED BY SWABBING OUT THE LARYNX.—Dr. Durodié, of Bordeaux, recently had under treatment a case of croup in a child seven years of age, in which tracheotomy became indicated. The parents, however, refused to sanction the operation, and the doctor, as a last resort, determined to swab out the larynx according to the plan first recommended by Dr. Green, of New York. The child was securely held, and the left index-finger of the operator was introduced into its pharynx as far as the opening of the larynx; a small sponge, which was firmly secured at the end of a piece of curved whalebone, was then dipped into warm water, and, guided by the finger, was pushed into the larynx, where it was rapidly moved up and down three or four times before being withdrawn. This manœuvre was repeated three times at each visit, and each time the sponge, when withdrawn, was covered with the debris of false membranes. This treatment was continued four days, when all danger of asphyxia disappeared. When the treatment was begun, the patient was in the last extremity, and the improvement was manifest at once. Dr. Durodié thinks that the success was due in part to the reflex spasmodic movements provoked by the contact of the sponge with the laryngeal mucosa, these movements causing the ejection of the portions of the false membrane left by the sponge.—*Gazette des Hôpitaux*, June 19.—*Medical Record.*

EPITHELIOMA OF THE CERVIX UTERI.—(*Demilt Dispensary*).—Mrs. S., native of Ireland, forty four years old; married twenty years; several children; last living child, November 14, 1872. In June, 1873, miscarried at six months; cause unknown. December, 1874, had a second miscarriage, at third month; cause unknown. Since this time, for more than two years, patient's health has been failing. Menstrual flow profuse. Often between periods would lose blood for a couple of days at a time. Sometimes slight watery discharge from vagina; severe backache. Sexual intercourse painful, and followed by a discharge of blood from the parts. Has lost twenty-five pounds in weight during this time; has a poor appetite, and for the past three months has been in destitute circumstances, and consequently unable to obtain sufficient suitable nourishment.

Patient evidently much emaciated, with the peculiar anxious, cachectic expression which indicates a painful constitutional disease.

Physical Examination.—A dark, grumous, fetid fluid is found exuding from the vagina. Cervix uteri in normal position, but ragged and uncerat around external os. Finger could be crowded to cervical canal for one-half inch. Tissue slightly gritty to the feel, and easily broken down, bleeding freely. The sound passed easily through the internal os after entering the canal above the diseased portion for three and a half inches. Place

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patient in knee-chest position, with Sims's speculum it was found that the cervix around external os and lower portion of cervical canal was diseased. The fungous growth was red and granular. The surrounding cervix was smooth, swollen and slightly indurated.

Diagnosis.—Epithelioma of the cervix commencing at external os. Diagnosis confirmed, at a later date, by Dr. E. R. Peaslee.

Treatment.—Patient placed in knee-elbow position. Applied strong solution of perchloride of iron and muriatic acid (℞. Liq. ferri perchl. ʒij; acid muriat. ʒj, M.), by means of a glass rod, to the affected parts. Five minutes afterward the whole of the diseased tissue was scraped away with a Sims's curette, and a fresh application made of the same medicament, to the slightly infiltrated base. Opium was given *pro re nata*; compound tincture of cinchona and the muriated tincture of iron were ordered, and arrangements made for improved diet, including an abundance of milk. Ordered injection of warm water with alum and carbolic acid once a day.

February 5th.—Has suffered great pain. To continue same remedies. No application made today.

9th.—Quite comfortable; much less pain; no hæmorrhage for several days. Iron and acid again applied to diseased surface; and all fungous growth removed with curette, as before.

March 10th.—Disease has made no progress since last treatment; size of cervix much diminished; ulcerated surface diminished one-half. Again applied iron and acid. Continued tonics; opium *pro re nata*.

April 10th.—General improvement of patient and disease. Iron and acid has been applied every two weeks. Has had no hæmorrhage excepting at menstrual epoch, when it is still profuse.

June 8th.—Patient in better condition. Some erosion still existing about external os. No pain in or about pelvic organs. Same treatment to be continued.—*N. Y. Medical Journal.*

REMOVAL OF A LARGE FIBROID UTERUS WITH BOTH OVARIES.—Mr. Krowsley Thornton relates a case in which recovery took place after removal by gastrotomy of a large fibroid uterus with outgrowths, and both ovaries. The patient was 38 years old, married, but had never been pregnant. The tumor had been first noticed nearly three years before. The operation was performed on January 10th. In opening the peritoneum a coil of intestine was wounded by the point of the knife, but the wound was at once closed by a continuous suture of fine silk. The pelvic portion of the tumor could not be dislodged, until the mass of the tumor was drawn out of the incision and used as a lever, by being pressed over the left iliac crest. This mass was then transfixed and ligated

with two strong strings, and it was then cut off. Room was thus gained to get at the broad ligaments, which were transfixed and tied with double ligatures. The ovaries were then cut away. Finally the cervix was transfixed and tied, and the mass above it cut away. All the ligatures were cut short, and the abdomen was closed. The operation occupied rather more than an hour and a half. The ice-water cap was used on two occasions in the after-treatment, the temperature having risen to about 101°. On the ninth day some red, offensive serum came away per vaginam, and this discharge continued till the eighteenth day. It then ceased, and at the same time pain was complained of in the right iliac region, and the pulse rose to 124. On examination by speculum a small slough was found plugging up the external os, and on pulling it away a quantity of fetid pus escaped. Convalescence then progressed favourably, and on the thirty-seventh day the patient was able to go out.

Mr. Thornton believes that this is the first successful case of removal of the uterus and ovaries, in which all the pedicles were tied with silk and left free in the peritoneum. He prefers this to the extra-peritoneal method, thinking that it is attended by less danger of septicæmia or of hæmorrhage, experience having shown that danger of hæmorrhage when the clamp or wire separates is by no means small.—*Obstetrical Journal*, June, 1877.—*Med. Record.*

REMOVAL OF LYMPHATIC GLANDS FROM A CHILD. Dr. A. C. Post (N. Y. Path. Society), presented a mass of lymphatic glands, weighing about two pounds, which he removed from a child four years of age. The first evidences of enlargement were noticed about a year previous, and at first they increased slowly; latterly, however, they grew very rapidly, and began to impede the respiration. At the time of operation the mass extended from the lower jaw to the clavicle, and inward toward the median line. The operation was tedious, extending over a period of two hours, during which time the patient was under the influence of ether. A suggestion of the late Dr. Alexander H. Stevens was found to be of marked benefit in avoiding hæmorrhage. It was to cut directly down on the mass, and then enucleate as far as possible, using the knife merely to cut bands of connective tissue. In this way, although the enlarged glands skirted along the dilated vessels, no dangerous hæmorrhage followed. It was feared that the prolonged anæsthesia might possibly prove fatal, and the mother of the child was forewarned. Fortunately, however, both the pulse and respiration continued good. On the morning following the operation the child was able to sit up in bed.

In answer to a question, Dr. Post said the suggestion of Dr. Stevens applied only to benign tumors.

In malignant tumors it was an important principle to err on the safe side, and remove as much of the surrounding tissues as possible, so as to lessen the chances of recurrence.—*N. Y. Med. Journal.*

Medical Items and News.

GROUND mustard rubbed on the hands will remove the odor of valerian, musk, cod-liver oil, carbolic acid, etc.

DR. MATTHEWS DUNCAN.—It is now, we understand, definitely settled that Dr. Matthews Duncan will leave Edinburgh and settle in London, having been elected to the office of Obstetric Physician at St. Bartholomew's Hospital, on the resignation of Dr. Greenhalgh. There is in all circles in Edinburgh a general feeling of regret at losing one who has so long held a leading position in the medical profession there, and whose advice on matters of public business was much sought and highly valued, as being that of a clear-headed, thoroughgoing, and independent man. By the Medical School the loss will be particularly felt, as he is recognised on all hands as being one of the most able and successful of teachers. It is the intention, we are informed, of his medical brethren and others to entertain Dr. Duncan at a banquet before he leaves. His resignation will throw open the offices of the Physician for Diseases of Women at the Royal Infirmary, and that of Ordinary Physician to the Royal Maternity Hospital, for each of which appointments more than one candidate is already in the field.—*Brit. Med. Journal.*

ON EMPYEMA.—In the last volume of Guy's *Hospital Reports*, Dr. Goodhart discusses the question of operative procedure for empyema. Although recognizing that there are a few cases which may be safely let alone, he gives in his adhesion to operation by a single free opening, with antiseptic measures, and with a large drainage-tube, as being the most effectual means of cure. He insists upon the necessity of making the opening as low as possible, fixing the point at the ninth intercostal space, opposite to the angle of the rib, the seventh space in the axilla, or the eighth between the axilla and the rib-angle. Further back there is risk of wounding the lung compressed against the spine, and below these points the peritoneal cavity may be entered. A large number of cases are given, with full details.—*Medical and Surgical Reporter.*

OPERATIONS FOR PHIMOSIS DURING THE PRESENCE OF A CHANCRE.—Dr. Eustach Antoniewicz (*Wiener Med. Presse*) cites the views of a large number of authorities who advise against an operation for phimosis (otherwise indicated) during the continuance of a specific ulcer; most of them fear

the extension of the ulcer to the wound made by the operation. The author then details five cases in which he made the operation, and in which the wounds thus made rapidly closed, and were followed by no extension of the chancre. He claims that the cure was accelerated. The average time before closure of the wounds in these cases was thirteen days, while in a number of others, not so treated, the ulcer lasted twenty-four days. He recommends the plan, therefore, because it hastens the cure, and the wound is not attacked by the ulcerative process.—*Schmidt's Jahrbücher*, No. 7, 1877.—(*Clinic*)

NEW METHOD OF TRACHEOTOMY SPECIALLY APPLICABLE IN YOUNG CHILDREN.—Dr. J. J. Reid, of New York, advises the following method of operating:—After the usual incision of the skin, and the division of the strong superficial fascia which connects the sterno-hyoid muscles, the knife is laid aside, and the next part of the operation performed by two uterine tenacula. With these the deep layers of fascia are torn, and the thyroid veins are pulled aside until the trachea is sufficiently exposed. The tenacula are then inserted into the sides of the trachea, and slight traction is made, while the tube is laid open to the desired extent with a bistoury. The wound in the trachea is thus made to gape widely, and any piece of membrane can be removed and the tracheotomy tube easily introduced. The advantages claimed for this method of operating are that it reduces to a minimum the risk of hæmorrhage, serves to fix the trachea without the danger of compression of the trachea and larynx, and facilitates the introduction of the tube.—*The Doctor.*

CÆSAREAN SECTION AFTER DEATH—DELIVERY OF A LIVING CHILD.—Dr. Buckell, of Winchester, reported to the Obstetrical Society (*Medical Times and Gazette*) the notes of, and showed the viscera of a case in which Cæsarean section was performed twenty to thirty minutes after death. The child was saved. The mother died suddenly of dilatation of the aorta, rendering the aortic valves incompetent. At the post-mortem examination the viscera of the chest and abdomen were found to be transposed. The president thought the case of interest, as showing that a child could be recovered a considerable time after the death of the mother. Dr. Aveling said that it is believed that a child may be born alive an hour after the mother's death. Dr. Playfair said he knew of one case in which a live child was born half an hour after the death of the mother. Dr. Routh said that much depended on the cause of the mother's death. He had performed Cæsarean section in a case from apoplexy, but the child was dead from carbonized blood. Dr. Daly saw Cæsarean section done twenty minutes after rupture of the uterus, but the child was dead.—*Amer. Four. Med. Sciences.*

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THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science

Issued Promptly on the First of each Month.

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TORONTO, DEC. 1. 1877.

THE PENGE CASE.

This case which has lately been a subject of such great interest to the Medical Profession in England, and which has just been terminated by the Home Secretary granting a free pardon to one of the convicts, and commuting the sentence of the others to imprisonment for life, has, we think several important lessons for us in Canada which should not be overlooked. The decision arrived at by Mr. Cross implies no doubt of the guilty intention of the prisoners, but is a result of a memorial signed by seven hundred and thirty-three medical men expressing their opinion that the post mortem appearances of the body of Harriet Staunton were not such as to justify the conclusion that death was caused by "starvation, or any other form of murder."

We do not propose to go into the case itself, with which our readers are no doubt familiar, but to call attention to those points which affect us as medical witnesses in a Court of Justice, and as pathologists. The first point that concerns us, is the increased difficulty there will be hereafter in proving death by starvation. This case, remarkable for the utter failure of the medical evidence to prove what was required from it, will be a standard one to the counsel for the defence in all future charges of a similar character. The medical witness in such a case in future, will not have to rest satisfied with proving that the results of insufficient supply of nutriment to the body were present; he will also be required to be in a position to affirm that these results were not consequent on inability on the part of the deceased to assimilate food, if it had been supplied. In other words, he will be required to prove that both the will to take food, and the power to digest it were present, and the

absence of any disease that would neutralize the benefit of food taken and digested, before he can say that the patient died from being deprived of it. And in giving such evidence, he must be uninfluenced by anything beyond what can be deduced from a careful and thorough examination of the patient during life and after death. We are all conscious of how ready we are to be influenced by the surroundings of a case in forming an opinion; of how ready we are to jump to a conclusion as soon as we have observed one fact on which to found it, and to cease looking further. This tendency has been painfully exhibited in the unfortunate case to which we refer, and we also see how easily it may lead to a failure of justice.

The second point about which we wish to say a few words, is regarding the care required in making post mortems, and the competency of those making them. One unfortunate result of the limited opportunities for anatomical research in this country is, that it is almost impossible for the student to become sufficiently familiar with the appearances of diseased tissues to be able to recognize them as he ought. After entering into practice, his opportunities in the majority of cases of seeing or making post mortems, are practically nil; and a great part of what he had learned, is forgotten, when perhaps some case occurs suddenly requiring large anatomical and pathological experience to enable him to give a correct opinion, the lack of which may lead to the escape of the guilty or the conviction of the innocent. This deficiency is felt in England where the opportunities for pathological research are far in advance of those here. The evil consequently exists to a still greater extent among ourselves, and leads to a great deal of that difference of opinion which is the reproach of the medical profession.

Want of care in making the post mortem sometimes occurs, and though it is to be hoped this is rare, yet cases within our own knowledge have shown that it does take place. One instance of this happened not many years ago, in a case in which a man was tried and convicted of poisoning his wife. The medical man who made the post mortem neglected to tie the stomach before removing it, and so allowed the contents to escape into the abdominal cavity from which he removed them by scooping up what he could with his hands. The jar containing the viscera also remained unsealed for several days before it reached the

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analyst's hands. Such omission might easily render the evidence of both medical man and analyst worthless, and would not have occurred had the operator been more *au fait* at his work.

The failure of the medical evidence in the Penge Case has led to a renewed feeling amongst the profession in England that the most effectual remedy for such occurrences in the future would be the appointment of men noted for their experience and ability in observing post mortem appearances, whose duty it should be to conduct post mortems in criminal cases; men whose familiarity with the subject would render them less liable to err in interpreting what they saw, or to overlook any condition that might have in any way influenced the death of the person. In England, it is probable that persons so appointed would have their time so fully occupied that they would be able to devote their whole attention to the work. In Canada it would not be so, and the difficulty of finding suitable men for such a position would be great, as there are so few here who are able to dispense with practice and cultivate a speciality of this kind. We believe, however, that a great improvement on the present mode of conducting post mortems in cases the subject of legal inquiry, might be made if the Government were to bring in an Act empowering the Minister of Justice to appoint certain men in the larger cities, who might be called by the coroner to aid the local medical man in conducting the post mortem in all cases of death under suspicious circumstances; such men to be entitled to receive fees and travelling expenses at a fixed rate in all cases in which they might be called on to act. It would not be difficult to find men in Toronto or Montreal connected with the Hospitals whose opportunities there, are sufficiently great to render their opinion of weight, and the experience they would gain would go far in time to remove the doubt and uncertainty so frequently attendant on medical evidence in criminal cases. The experiment would, we think, at any rate be worth trying, and in the long run would not probably increase the cost of the administration of justice, while it would probably improve its efficiency.

VIBURNUM PRUNIFOLIUM.—Fluid extract of viburnum prunifolium is being used with gratifying success in cases of threatened abortion, uterine debility, irritability and hemorrhagia, by the profession in the United States and Canada.

ENQUIRY INTO RECENT DOUBTS OF THE VALUE OF VACCINATION.

It has been considered by a few physicians in recent years that vaccination is not only useless but an evil; that Jenner's theory has no foundation in physiology, nor any philosophical basis; and that there is no instance in which the inoculation of one disease prevents another. They also state that the general mortality has not been diminished by vaccination; that the argument that vaccination has diminished small pox, is merely *post hoc ergo propter hoc*, and overlooks other concurrent circumstances; that small pox is not the horrible and dangerous disease it once was, its treatment being much better understood:—also that if it does stand as a preventive of small-pox, the chances are millions to one, that it imports other and more powerful disorders into the system. That as cow pox is generated in dirty byres, and horse grease in dirty stables; so small pox prevails among the dirty, low, ill fed, unwashed population. That as the plague, jail-fever, leprosy, elephantiasis, sweating sickness, and black death have passed away with advancing civilization, so has the cow pox of Jenner. Further, that cleanliness is the great prophylactic against epidemics, small pox included. Civilization has banished many epidemic diseases, and ought to have got rid of small pox. It is also stated that the excessive mortality of recent epidemics is to be attributed to confinement in small pox hospitals which necessarily occasions a great increase of mortality by the congregation of a number of cases in a limited area—and that cow pox weakens the power of vitality and imparts or calls into action diseases which would otherwise remain dormant, as syphilis, scrofula, skin diseases, etc.

To meet these numerous objections we cannot do better than furnish our readers with a *prima digest* of the evidence taken before a committee of the English House of Commons (see Blue Book). Mr. Simon, F.R.S. has formed his opinions on vaccination as a preventive of small pox, not on his experience as a practical medical man, but as a medical statistician by considering masses of national evidence, and as a reader of medical history. He considers small pox in the absence of vaccination the most fatal pestilence.

It is not a declining disease; small pox contagion being always present, an unprotected

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person generally cannot get far into life without catching it. Against fatality or severity, where vaccination has been thoroughly good, it is almost absolute. There is not a shadow of pretext for asserting that the protective value of vaccination has decreased. It is the only protection against small pox, except isolation. Mr. Simon denies the accuracy of the assertion that the death rate is low when small pox is present, and high when it is absent. According to tables by Dr. Greenhow and Dr. Farr, in the middle of the last century when small pox largely prevailed, the general death rate was double what it is at present; and Dr. Guy shows that the small pox mortality from 1840 to 1854 was less than a tenth of what it had been. During the twenty years, 1660-79, when small pox reached 4170, the general death-rate is estimated at 80,000 per million; and small pox contributed a twentieth of a total three times as high as the present death rate. Destructive small pox epidemics then occurred, which have ceased where vaccination is general. In Ireland during 1830-40 the annual small pox deaths were 5,800 (pop. 8 millions); 1840-50, 3827 (pop. 6½ millions); 1850-60, 1272 (pop. 5,800,000.) In 1863 vaccination was made compulsory. In 1864 there were 854 deaths; 1865, 347; 1866, 187; 1867, 20; 1868, 19; and in 1869, 20 deaths.

Mr. Simon states that in the small pox hospital the mortality among unvaccinated patients is 35½ per cent.; among the vaccinated, proved by reference to scars on the arm, 7 per cent, and those done in the best manner a fraction of one per cent. In Holland the children are vaccinated very late, and thus it is that an epidemic of small pox has the power of attaining enormous dimensions. In India, where 98 per cent. of the natives above ten have small pox naturally or by inoculation, Dr. Harvey reports (1868-9) a death-rate in Agra, unprotected by vaccination, of 128 per 10,000. In Delhi less unprotected, 104. In Burtpoor, partially protected, 65; and in the British European army (protected) 3.59 per 10,000. He attributes the enormous difference entirely to want of vaccination. Mr. Simon thinks the different modes of the between the natives of India and the European troops would make no difference as regards the attacks from small pox, though it may possibly in the power of resistance; there is much greater likelihood the infection may spread where the people

are huddled together, but barring that, is not aware that sanitary influences exert much control over small pox. There has been a great reduction of some diseases, but small pox left to itself is the same disease as it was two or three centuries ago. If there were increased infant mortality in any place he would expect to find that its sanitary condition had deteriorated, certainly not from vaccination.

He further states that there is not the least doubt that syphilis has on several occasions been communicated on the continent by what has purported to be vaccination. He mentions a case where vaccination was performed by a porter of the Paris Academy of Medicine, and what purported to be vaccine lymph was taken from a child covered with syphilitic skin disease, of which it died in a few days. A vaccinator should assume that lymph taken from a syphilitic subject would convey syphilis; but the negative evidence is very great as to syphilis not spreading by average vaccination. Sir B. Brodie had never seen a case where vaccination could be supposed to have imparted syphilis. It is absurd to suppose scarlet fever has been communicated by vaccine. An occasional death within seventy years has arisen from the contagion of erysipelas caught by the vaccinated arm, but never knew a case of pyemia induced by vaccination. Mr. Gibbs has entirely misapplied the experiments of Dr. Wilson Fox, who denies that vaccination, as such, has ever been known to produce tubercle; there is not the smallest reason to suppose that tubercular disease is communicated by vaccination. Mr. Simon believes that fears of vaccination are scarcely entertained, except where pains are taken to exaggerate occasional mischances. Vaccination is perfectly indifferent to life except as serving to cut off the one great danger—small pox. Ricord is of high eminence; but he certainly does not agree with him, that syphilis being found communicable by vaccination, the practise must cease. Experience shows that while vaccinations are annually done in millions, allegations that would bear examination, are of the utmost rarity in regard to syphilis being so communicated and the risk is quite infinitesimal.

The testimony of Dr. Bakewell, Vaccinator General of Trinidad, Sir D. Corrigan, Mr. Marson, thirty-five years surgeon to the Small Pox Hospital; Dr. Wood, Prest. R. C. P., Edinburgh; Sir

Wm. James, Dr. Gull, 25 years physician to Guys Hospital; Dr. West, physician of the Children's Hospital; Mr. Hutchinson, surgeon to the Lono-phththalmic and skin diseases hospitals; Dr. Seaton, Medical Inspector Privy Council, corroborates the views of Mr. Simon of the protection afforded by vaccination against small pox. Their evidence will also be found in the same book.

CONFERENCE WITH THE AMERICAN MEDICAL ASSOCIATION.

At the meeting of the Canada Medical Association held at Niagara Falls in 1874 it was resolved that, "in consideration of the true interests of Medical Science, it is desirable that a medical conference should take place between the American and Canada Medical Associations at some central point to be determined upon; and that the American Association be advised as to the desirability of thus becoming more intimately acquainted, and affording an opportunity for the discussion of medical and surgical questions on a common basis."

At the meeting of the American Medical Association in Louisville, in 1875, this idea was reciprocated, the subject was taken up, and it was resolved "that a committee of thirteen be appointed, whose duty it shall be to confer with a like committee of the Canada Medical Association at such time and place as may be agreed upon by the joint committee of the associations." The meeting of the joint committee took place in Philadelphia, in September, 1876, and it was unanimously resolved "that in the opinion of this conference the interests of medical science will be promoted by a consolidation of the Canadian and American Medical Associations in one body," and "that the president of each association respectively be requested to embody this idea in his annual address in order that the matter might be taken up and more fully discussed at the next annual meeting."

Dr. Bowditch, President of the American Medical Association, at the annual meeting in June last, took up the subject in his address and placed the arguments *pro* and *con*. before the association. In favor of the plan he mentioned the following reasons:—

First, We should associate ourselves with a body of physicians, all of whom have been educated

under English influences, and many of whom have pursued their studies in England and have received diplomas from the schools of that country. We all know the high standard of qualifications required by the British schools.

Second, Why may we not look upon such a connection, as quite similar to that which has frequently taken place and which will occur hereafter when a new State in this Union is formed?

In that case, if a State medical society be organized, it has a right to send delegates to this association. The only difference, in the two cases, would be that Canada embraces a very much larger constituency than any of our new States would have.

Third, I am inclined to look with favor upon the proposed union from the standpoint of civilization itself. There can be no doubt, as already stated, that this American Association has been a great means for promoting good-will between the different sections of the United States. The proposed Union with the Canada Association will tend much towards the reuniting of two of the free nations on the globe, and certainly civilization can get only good from such co-operation. All that we can bring to unite mankind I hail with delight.

Fourth, I will allude to what would give me, I doubt not, many more, great pleasure. I wish the united professions to meet in the old cities of Montreal and Quebec, and pass up and down the noble St. Lawrence, magnificent as it is in length, depth, and breath of its waters, and more fascinating from its early associations with European civilization. I would like that we should all stand on the scarred battlements of Quebec, and I think, perhaps, we, of this country, may learn a divine lesson of magnanimity after we could together look at the obelisk, erected to the graceful action of the British Government, to the joint memories of Wolfe and Montcalm, the brave soldiers, antagonists in battle, but, in due joint heirs in the memories of mankind."

The objections to the proposed amalgamation were chiefly: the unwieldiness of the united body, the American Medical Association being already much too large a body; the difficulty of arranging the expenses; the widely distant places of meeting in the two languages spoken throughout the continent &c., &c. The judicial committee to which the subject was referred by the president reported

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against it and expressed the opinion that the present system of intercourse by delegates served to meet the requirements.

The subject of amalgamation was also dealt with by Dr. Hingston in his address before the Canada Medical Association in September last (see "Transactions"), in which he repudiated the idea of amalgamation on the part of the Canada Medical Association. He said:—"The Canada Medical Association did not ask for amalgamation, or to absorb or be absorbed by the American Medical Association; but merely for "a conference at some central point" so as to become "more intimately acquainted," and to discuss "medical and surgical questions on a common basis."

If our representatives at Philadelphia asked for more, they were not so commissioned; and in resolving that "a union of the two associations into one is desirable," they expressed their own views, advanced and liberal, no doubt,—but spoke not for the Canada Medical Association, which, at Niagara in 1874, asked merely for a "medical conference," for the "discussion of medical and surgical questions on a common basis" without either association losing, or wishing to lose, its identity.

He also said that "union for scientific purposes was alone possible," but that all matters pertaining to medical ethics or education could not possibly have been discussed or settled by two peoples so near each other in many things, so far asunder in others." We fully endorse the sentiments expressed by Dr. Hingston, and trust that the two associations may have a long career of usefulness before them, each in its own sphere, and that the closest friendship and mutual good-will may always exist between them. The system of sending delegates each to the other association cannot, at least for many years to come, be improved upon.

BOVINE VIRUS, NEW STOCK.—A case of spontaneous cow-pox has lately occurred among the herd of Mr. Leuey, of Longue Pointe, Quebec. Dr. Messey, of Montreal, district physician, has been successful in securing and propagating this virus under the name of the "Leuey Stock." It is now being used by the Board of Health, Montreal. It has also been used by several medical gentlemen in Montreal with the most satisfactory results. Dr. Messey now offers it to the profession with the full confidence in its purity and reliability.

TURKISH ARMY MEDICAL SERVICE.—The Turkish Army Medical Service is said to be in a most deplorable condition. It is totally inadequate in numbers and quality, and the condition of the sick and wounded is most distressing. The supplies are scanty, and the unfortunate wounded are days without any relief, surgical assistance, or even food. After a battle near the Shipka pass in which 6,000 were wounded, there were only four surgeons to look after them. The English and foreign surgeons who have gone to the seat of war have not been very cordially received, and in some instances were forbidden to perform operations necessary to save the lives of the soldiers. The Turkish medical officers at Erzeroum refused to allow amputation to be performed, because "it was better the men should die than become a burden on the Sultan." Instead of the inhuman Turks being thankful of assistance, the English aid societies have actually to compel them to receive help for their sick and wounded.

NO EXCUSE FOR ANY ONE BEING OUT OF EMPLOYMENT.—Our attention has been called to some new and useful household inventions recently patented by L. E. Brown & Co., of Cincinnati, Ohio, which make housekeeping a pleasure, instead of a dreaded necessity. They have been having a very large sale for them throughout the United States, and now wish to introduce them through the Dominion of Canada, and offer good reliable lady or gentlemen canvassers an opportunity seldom met with for making money rapidly. For terms and territory write at once to L. E. Brown & Co., 214 and 216 Elm Street, Cincinnati, Ohio.

IMPROPER REGISTRATION.—Dr. F. D. Gilbert, of Sherbrooke, Que., has brought a charge against Dr. G. E. Fenwick, of Montreal, and Dr. E. D. Worthington, of Sherbrooke, of issuing a false certificate of registration to a physician, to enable them to secure the proxy of the latter at the election of the board at Three Rivers, Quebec. The case is now before the courts for investigation, and we refrain from any comments at present. We hope for the credit of the profession in Quebec that the whole matter may be satisfactorily explained.

HEROIC CONDUCT REWARDED.—A pleasing incident at the meeting of the British Medical Association, was the presentation of medals to several

medical men, for their heroism in assisting in the rescue of miners in the colliery accident in April last at Point-y-Pridd. The doctors were unremitting in their attention, and by their presence cheered and encouraged the miners to persevere in their attempt at rescue. Drs. Dukes and David were the first, who, after communication had been established, crept through the narrow channel at the peril of their lives. Silver medals were awarded to each, and the gold medal to Dr. Davies, the colliery surgeon, who superintended the efforts of the men, remaining whole days and nights in the pit. Bronze medals were awarded to several others who rendered essential service.

THE JEFFERSON MEDICAL COLLEGE HOSPITAL.

—The new hospital of the Jefferson Medical College has recently been opened for the reception of patients. It is built of brick with Ohio stone facings, five stories high, and consists of two wings in the shape of the letter L. Within the angle is a two-story amphitheatre capable of seating 600 students. The building is heated by steam, and fresh air is obtained by openings beneath the windows and behind the steam heating coils; also by ducts opening from the street into the basement, where it is heated and passes into the various parts of the building through flues and registers. The opportunity for clinical instruction here will be very good, and clinics will be held throughout the winter and summer sessions.

TRINITY MEDICAL SCHOOL ANNUAL DINNER.—

The annual dinner of the Faculty and Students of Trinity Medical School, was held in the Queen's Hotel on the 21st ultimo. The chair was occupied by Mr. Charles Sheard, and the vice-chairs by Messrs. W. H. Doupe and B. Spencer. Among those present as invited guests were Mr. Justice Morrison, Senator Campbell, Hon. William Macdougall, Hon. M. C. Cameron, His Worship the Mayor, Alderman Boswell, Rev. Dr. Topp, Mr. S. B. Harman, Mr. W. S. Lee, Mr. Thomas McCrosson, Mr. VanKoughney, Drs. Workman, Clark, Payne, O'Reilly, Barrick, Canniff, Moorehouse, More, Stuart, Teskey, N. M. Geikie, and others. The band of the Tenth Royals was stationed in the gallery, and during the evening rendered some fine selections in good style. Letters of regret were received from several invited guests who were unable to be present. After dinner the usual loyal and patriotic toasts were proposed and duly hon-

ored. The toast of the "Dominion and Local Legislatures," was responded to by Hon. William Macdougall and Hon. M. C. Cameron; the "Army, Navy, and Volunteers," by Drs. Holder and Kennedy; the "Universities with which we are affiliated," by the Hon. Justice Morrison, for Toronto University; S. B. Harman, Esq., for Trinity University; and Mr. Henderson for the University of Halifax. The toasts of the "Dean and Faculty of Trinity Medical School," was responded to by Drs. Hodder, Bethune, Geikie, and Fulton—all of whom were loudly applauded. The secretary, Dr. Geikie, gave an account of the condition and prospects of the school, and stated that upwards of 130 students had registered themselves during the present session. Dr. Fulton after alluding to the success of the school, referred to the advantages afforded by the Toronto General Hospital, and paid a high compliment to the Board of Trustees for the high state of efficiency into which that institution had been brought, and to the resident Medical Officer, Dr. O'Reilly, for the care and attention which he brought to bear in the discharge of his duties. The toast of "The Canada Medical Association," was responded to by Dr. Workman, President elect, in a humorous speech. After toasts to the "Medical Council," "The Medical and other Learned Professions," "The Graduates and Class of the present Session," "The Ladies," and "The Press," all of which were interspersed with singing by the students, the company broke up after midnight having enjoyed a very pleasant evening's entertainment.—[COM.]

ANNUAL DINNER OF THE TORONTO SCHOOL OF MEDICINE.—The annual dinner of the Toronto School of Medicine was held at the Rossin House on the 9th ult. In addition to the faculty of the school and students the following gentlemen were present: Mayor Morrison, Drs. Workman, Clark, O'Reilly, Riddell, Fraser, Langstaff, Griffin, MacPhedrain, Winstanley, Pyne, Bascom, Cameron, Schmidt, White, and Black. Upon the removal of the cloth, letters of apology were read from several invited guests, after which the usual loyal and patriotic toasts were proposed and responded to. Several humorous songs enlivened the proceedings between the speeches. The evening was spent very pleasantly by all present.

TRINITY COLLEGE CONVOCATION.—The annual convocation of the University of Trinity College was held on the 15th ult., in the new Convocation Hall. The following gentlemen received the degree of M.D.—W. W. Geikie, C. F. Patten, G. Stark.

Matriculants in Medicine.—E. Thurgeson, J. H.

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OPIUM CURE HOSPITAL.—We take pleasure in calling the attention of the profession of Canada to the Parish Hall of Brooklyn, N. Y., a home for the cure of opium habitues. It is the only one of its kind in existence on this continent, and from the high character of the men who are at the head of the institution, it may be confidently recommended as a suitable place for this unfortunate class of patients. The Home is delightfully situated near Prospect Park, is handsomely furnished and provided with every necessary arrangement which experience has shown to be of value in the treatment of such cases.

NEW MEDICAL REGISTER.—It is the intention of the Ontario Medical Council to issue a new Medical Register early in 1878. It is to be hoped, therefore, that the registered medical practitioners of the Province will see that their names and addresses are properly entered, and that wherever any changes or additions are desired, they will communicate without delay with the Registrar, Dr. Pyne, Toronto.

ROGER'S STATUARY.—The groups of statuary manufactured by Mr. Rogers 1155 Broadway New York, cannot be excelled for correctness and life like expression. "Playing doctor," "The charity patient," "School days," the "Travelling Magician," are among the very best, and as works of art, are beyond criticism. Either of the above would be very nice and suitable for a Christmas present. They only require to be seen to be appreciated.—Send for catalogue.

TREATMENT OF THRUSH—APTHÆ.—This affection, which is very common in children, requires both local and constitutional treatment. It frequently arises from some derangement of the digestive organs. When the general condition is good

it suffices to apply a wash to the inside of the mouth and gums, three or four times a day, and the following applied by means of a piece of soft lint tied on the end of a piece of whalebone, will be found very serviceable.

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Sod. Bibor, *aa.* ʒiiss.
Glycerinae, ʒss.
Aquæ, *ad* ʒij.—M.

APPOINTMENTS—Prof. Thos. Annandale has been appointed to the chair of clinical surgery in the University of Edinburgh as the successor of Prof. Lister.

S. S. Murray, M. D., of North Dorchester, to be an associate coroner for the county of Middlesex.

EXAMINERS IN TRINITY COLLEGE.—The following gentlemen have been appointed examiners in medicine for Trinity University, viz: Drs. Kennedy, Robertson, Stuart, Teskey, Toronto; and Dr. D. B. Fraser of Stratford.

Books and Pamphlets.

THE POCKET CASE-RECORD AND PRESCRIPTION BLANK BOOK WITH VISITING LIST, by R. Clarke & Co., Cincinnati.

This book furnishes a convenient method of keeping copies of prescriptions and notes of cases in private practice at the bedside. It contains spaces for the names of patients, date of visit, age, diagnosis, pulse, temperature, respirations, &c., and a visiting list which will accommodate the largest practice. Send thirty-five cents for a sample Messrs. Clarke & Co., also publish an Office Case Record and Prescription Blank Book, and a Physicians Case Record Ledger, which will be found exceedingly convenient and useful.

PHYSICIAN'S VISITING LIST, by Wm. and A. D. Elmer, New York; W. A. Townsend Publisher. The above mentioned list has been long before the profession, and the new edition will be welcomed by many who have formerly used it.

WALSH'S PHYSICIAN'S COMBINED CALL-BOOK AND TABLET, third edition, price \$1.50.

This is an exceedingly neat and comprehensive physician's visiting list. It is of the size and shape

of an ordinary wallet, and can be carried in the pocket without any inconvenience. It contains many useful tables, formulæ and doses of medicines and new remedies, directions for examining the urine, making post-mortems, etc. This visiting list is well got up, and cannot be too highly recommended. Dr. Walsh also publishes a **HANDY LEDGER**, a companion to the Call book and Tablet, price \$2.50. Both of the above may be had by addressing Dr. Walsh, 326 C. St., Washington.

PHYSICIAN'S VISITING LIST, by Wm. Oldright, A.M., M.D. Toronto: Wm. Warwick, price \$1.25.

The advantages which are claimed for this work are, that being ruled for a month instead of a week, the names of patients are written but once in the month, and that on this account, it is also more convenient for posting.

NINETEENTH ANNUAL REPORT OF THE HOSPITAL FOR INSANE, Nova Scotia, for 1876. Dr. J. R. DeWolf, L. R. C. S. E., Medical Superintendent, D. A. Fraser, M.D., Assistant Physician.

It is evident from a careful perusal of the report before us, that this institution is doing a good work. On the first of January, 1876, there were 318 patients in the hospital.

TRANSACTIONS OF THE CANADA MEDICAL ASSOCIATION.

This work which has just been issued from the press forms an octavo volume of 240 pages, with seven full sized plates, and contains the proceedings, President's address, reports of committees, and eight Medical and six Surgical papers. The price is \$1.25. Subscriptions and orders should be sent to Dr. Osler, 1351 St. Catherine Street, Montreal, Secretary Publication Committee.

THE PHYSICIAN'S SELF-COPYING PRESCRIPTION BOOK AND BLANKS; by W. A. Anderson, Lacrosse, Wisconsin. Chicago: Hadley Bros. & Co. Price 35cts. each.

The above is a blank prescription book, arranged with carbon paper which enables the practitioner to write his prescription in duplicate with an ordinary lead pencil, one copy of which is retained and the other sent to the druggist. There is also a space on the retained prescription for recording the pulse, temperature, respirations, &c. This pocket companion will be invaluable to those who are in the habit of keeping copies of their prescriptions, and every one should do so.

THE MEDICAL REGISTER AND DIRECTORY OF THE UNITED STATES; by S. W. Butler, M.D. Second edition, revised and corrected. Philadelphia: Med. and Surg. Reporter Office.

This is a very large and important work, containing as it does the names and addresses of all the physicians in the United States. All the inaccuracies and omissions of the first edition so far as known have been corrected. Besides the names of physicians, the work contains a fund of valuable information regarding medical institutions, hospitals, societies, health resorts, mineral springs &c., &c. It will be found a most convenient and useful work of reference at all times.

HOW TO USE THE OPHTHALMOSCOPE, by E. A. Browne, M. D., Liverpool: Philadelphia, H. C. Lea. Toronto: Willing & Williamson.

Births, Marriages, Deaths.

At Woodbridge, on the 25th Oct., the wife of Dr. Grant, of a son.

At Mount Pleasant, on the 30th October, the wife of Dr. Marquis of a son.

At Woodbridge, on the 19th ult., the wife of Wilkinson, M. D., of a daughter.

At Carleton Place, on the 15th ult., R. W. Bell, M. D., C. M., of Peterborough, to Nellie, youngest daughter of John Sumner, Esq., Ottawa.

At Millbrook, on the 14th ult., John Hunter, M. D., to Lizzie, eldest daughter of John Kenwick, Orono.

In Toronto on the 14th ult., John A. Stevenson, Esq., M. D., of London, Ont., to Annie Isabel, eldest daughter of the Hon. Wm. Proudfoot, Vice-Chancellor of Ontario.

At Brockville, on the 14th ult., Archibald Malloch, M. D., of Hamilton, to Francis Mary, daughter of the late Dr. Reynolds.

In Ottawa, on the 9th ult., Dr. Germain of typhoid fever.

OBITUARY.—The death of Paul F. Eve, M. D. Nashville, Tenn., aged 71 years, the distinguished American surgeon is announced. Also Dr. Matyn Paine, New York, the distinguished medical savant, aged 82 years.

* The charge for notice of Births, Marriages and Deaths is fifty cents, which should be forwarded in postage stamps with the communication.