MINIMUM DOSES OF IODIDE OF POTASSIUM IN FRONTAL HEADACHE.

By GEORGE HALEY, M.B., Ch.B., Wangaratta.

Having found minimum doses of iodide of potassium a most useful remedy in the treatment of frontal headache, I some three years since commenced using it in all such cases coming under my care, with a view to ascertain, if possible, what peculiar kinds of headache could be relieved by it. Up to the present time I had collected a great number of cases of frontal headache treated with small doses of the iodide of potassium, and a few of these cases were most interesting, inasmuch as they were very severe and were immediately relieved by the iodide; but I have, unfortunately had my notes on these cases destroyed. I shall, therefore, confine myself to a few remarks only, just to draw attention to the powerful anti-cephalalgic properties of this drug when used in small doses, without referring to the reasons I had for expecting it to give relief in frontal headaches. I have found, as a rule, that a heavy dull headache situated over the brows, and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food which sometimes approaches to nausea, can be completely removed in about ten minutes by a two grain dose of the iodide of potassium dissolved in half a wineglass of water, and this quietly sipped, the whole quantity being consumed in about ten minutes. The class of headaches I refer to seems to have no particular or definite cause, but I believe belong to that class generally known as sympathetic headaches. In many cases I have found the effect of these small doses simply wonderful—the person who, a quarter of an hour before, was feeling most miserable and refused all food, wishing only for quietness, would now take a good meal and resume his wonted cheerfulness. In one case, that of a young girl, set. 12 years, the frontal headache was always followed by very severe vomiting, lasting for a day or two, and then extreme prostration. Her attacks came on at intervals of about a fortnight. Now, when she feels the headache coming on, resort is had to the iodide of potassium in the above-mentioned dose, which at once removes the headache.
and prevents the sickness, &c., which always followed if she was without the iodide. She has now used this remedy for two years and, I believe, has always found relief from it. Another case in which the iodide acted like magic was one of hemicrania (the patient suffering at the time from an attack of acute ophthalmia), the pain extending from over the right brow back along the right side of the head. The one great advantage of this minimum dose of the potass. iodid. for frontal headaches, is the rapidity with which it acts.

REPORT OF 660 CASES OF MIDWIFERY IN AUSTRALIA.

By SAMUEL T. KNAGGS, M.D., F.R.C.S.I.

Late Senior Surgeon to the Newcastle Hospital, New South Wales. Member of Royal Society of New South Wales.

(Read before the Dublin Obstetrical Society, Saturday 2nd April, 1881.)

(Continued from p. 290.)

The following table shows at what period subsequently to the birth of the child the placenta was expelled in those cases where its delivery was effected by the natural action of the uterus:

<table>
<thead>
<tr>
<th>In what period the placenta was expelled</th>
<th>Cases</th>
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<tbody>
<tr>
<td>3 minutes</td>
<td>14</td>
</tr>
<tr>
<td>5 minutes</td>
<td>62</td>
</tr>
<tr>
<td>10 minutes</td>
<td>219</td>
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<tr>
<td>15 minutes</td>
<td>181</td>
</tr>
<tr>
<td>20 minutes</td>
<td>111</td>
</tr>
<tr>
<td>25 minutes</td>
<td>37</td>
</tr>
<tr>
<td>30 minutes</td>
<td>26</td>
</tr>
<tr>
<td>35 minutes</td>
<td>8</td>
</tr>
<tr>
<td>40 minutes</td>
<td>7</td>
</tr>
<tr>
<td>45 minutes</td>
<td>5</td>
</tr>
<tr>
<td>50 minutes</td>
<td>2</td>
</tr>
<tr>
<td>55 minutes</td>
<td>2</td>
</tr>
<tr>
<td>60 minutes</td>
<td>5</td>
</tr>
</tbody>
</table>

As a general rule I rarely allow the third stage of labour to exceed thirty minutes. As soon as possible after the expulsion of the placenta I adjust a binder, using a piece of unbleached calico about fifteen inches in width, which I apply in the manner practiced in the Dublin maternities.

18. Puerperal Fever.—From this calamitous complication I have had five deaths. The first case occurred in a delicate pluripara whose favourite child had been accidentally burnt to death a couple of months previous to her accouchement. This affliction had so preyed upon her mind that her health was undermined,
and she became haunted with that ominous forboding of impending death that becomes so fatal to a pregnant woman. It was her seventh labour, and it was accompanied by violent action of the uterus, alternating with inertia. It was a case of labour in which instrumental assistance would be invaluable; yet, for a long time she positively declined my repeated requests to be allowed to use forceps, and did not accede to my wishes until the soft parts of the passage became intensely hot and dry and the vulva edematous. She was seized with rigors on the third day, and died on the fourteenth day.

The second subject was a multipara taken ill at her ninth confinement, who had determined, with the aid of an ignorant nurse, to do without a doctor. When she had suffered six hours continuous and unavailing agony, past midnight I was sent for. I found the pulse 140, very weak, the patient incessantly vomiting, the vulva edematous, and the soft parts considerably swollen. The head of the child was impacted in the bony passages, and uterine action so violent that I dreaded rupture of the uterus at every moment, especially as the patient loudly complained of that cutting pain above the pubes, which is so ominous to the obstetrician. With considerable difficulty the short forceps were adjusted, and the patient delivered of a very large male child, which must have been dead for some time. An asthenic form of puerperal fever followed, which ran a course of about five weeks, terminating in death.

The third death occurred in the person of a broken-down delicate woman at her thirteenth labour, whose husband had caused her considerable worry and anxiety. When I arrived I found that the child had been born fully an hour, the placenta retained by inertia, and considerable haemorrhage had taken place. Notwithstanding prompt treatment and careful nursing puerperal fever set in, and she died on the sixth day.

The fourth was a multipara at her ninth labour, who, without my knowledge, got up on the third day to attend to her household duties; rigors followed, puerperal fever set in, and she died on the ninth day.

The fifth occurred in a fine healthy young woman at her fourth labour. Everything went well at the time. Twenty-four hours afterwards the nurse took upon herself to prescribe stewed raisins and oatmeal porridge as a purgative. This abominable mess at once disagreed with the stomach, and caused vomiting of an
uncontrollable nature. The lochia ceased, rigors set in, and death followed on the sixth day.

The first four cases occurred during the year 1874, during which scarlet fever, erysipelas, and septic fevers were very prevalent in all the Australian colonies. Numerous deaths from puerperal causes occurred in the practices of other medical gentlemen throughout the colonies, as well as in the same city where I was practising. Latterly, when such epidemics are prevalent, or, indeed, when any puerperal woman appears to be out of sorts, I saturate the system with sulphurous acid, which I prescribe in a pleasant form as an acidulated drink, sweetened and flavoured with the syrup of orange peel. My impression is that in so doing I guard against septic infection, and since I have adopted this treatment I have seen less feverish attacks following childbirth than I had previously noticed.

Three deaths, with the one from puerperal convulsions previously noted, make my average of deaths amount to 1 in 110—certainly a high percentage—but it must be remembered, that in an extensive practice such as I was conducting with the assistance of two other medical gentlemen, my juniors in the profession, the more serious cases, or such persons as anticipated bad times, would especially come under my care. I think, in estimating averages of deaths in any class of medical practice, the fact is frequently lost sight of that the more a practitioner gains the confidence of the public, the higher will be his average of deaths, from the very fact that the increase of public confidence causes a more extensive practice amongst a more serious class of cases.

Operations.—I have performed craniotomy once, version twice; I have used the forceps eighty-eight times, and the vectis once.

The craniotomy was necessitated in a primipara, during the delivery of a female child at full period, in consequence of an extreme narrowing of the antero-posterior diameter of the pelvis; no bad results followed, as evidenced by the patient becoming pregnant two months after the operation. I strongly advised for the second confinement that labour should be induced at the seventh month, but was overruled by a religious objection on the part of the relatives. This caused me very considerable anxiety, but I was fortunate enough to deliver her of a healthy male child at full period, by means of Simpson's long forceps, having first put the patient fully under the influence of chloroform. The child had a narrow tussle for his life. The resuscitation took fully
half-an-hour, during which a warm bath and friction were combined with Sylvester's method for promoting respiration.

The accompanying table will show the nature of the forceps operations and the circumstances under which they were indicated:

<table>
<thead>
<tr>
<th>OPERATIONS</th>
<th>Primipara.</th>
<th>Multipara.</th>
<th>Total.</th>
</tr>
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<tbody>
<tr>
<td>Craniotomy</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Long forceps</td>
<td>10</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Short forceps</td>
<td>42</td>
<td>22</td>
<td>64</td>
</tr>
<tr>
<td>Vectis</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Version and forceps</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Version</td>
<td>1</td>
<td>1</td>
<td>1</td>
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</tbody>
</table>

CONDITIONS REQUIRING OPERATIONS:

- To facilitate labour in cases where disproportion between head and passages
- Girl, 16 years of age
- Face to pubis
- Inertia
- Face
- Puerperal convulsions
- Pelvic deformity
- Subsequent to turning
- First boy after 11 girls
- Patient exceeding 30 years
- Twenty years since previous child

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<td></td>
<td>46</td>
<td>26</td>
<td>72</td>
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Forceps Cases.—I have used the forceps 88 times in 660 cases. With this operation I have used Simpson's long forceps 23 times, Ziegler's once, and the short forceps of Professor Inglis, of Aberdeen, 64 times. In making the distinction between long and short forceps, and in using two different instruments, it must not be inferred that I doubt the possibility of performing all forceps operations with one instrument; but I think, for the sake of scientific accuracy, that some distinction should be made between the high and the low operation, especially when our results are utilised in statistics.

Professor Inglis' forceps are virtually a modified curved Simpson's forceps, fitted with short clubbed handles, which enables them to be held as you would hold a corkscrew. The special advantages that I found them to possess are:—1, portability; 2, facility of application, without necessitating much trouble to or shifting of the patient; 3, improved power of traction; 4, improved power of guiding the traction; and 5, the absence of
necessity for skilled assistance. In applying Inglis' forceps, the patient is delivered while lying upon her back, the head supported upon pillows, the knees flexed, and the heels almost touching the nates; in point of fact, she is placed in the lithotomy position, with the midwife or attendant on the left side, controlling her hands and left knee. The operator kneels on the bed, or stands at the foot of it, while applying the instruments. It is optional which blade shall be introduced first, but the posterior one will be the more convenient. In consequence of the patient's position, the blade, once introduced, will remain in situ without being held, and leaves both hands at liberty for the insertion of the second blade. The late Professor Inglis first described it in the *Lancet* of December 22, 1866, p. 692.

Taking separately each of the first three years that I practised in the colony, what may appear to some an alarming increase in the proportion of forceps cases will be seen to be yearly exhibited in my practice—

1st year, in 51 cases, not one forceps case.
2nd " 78 " 7 forceps cases, 1 in 11.
3rd " 111 " 17 " 1 in 6½.

In my first year's practice I lost two infants from tedious labours, whose lives I think would or should have been saved by the timely use of forceps. I carefully and cautiously introduced the practice of using instruments as an aid to labour rather than a dernier ressort, and now, having attained a proportional average of 1 forceps case in about 7½ cases, I have no reason to be dissatisfied with the result. Only two maternal deaths* have occurred in the 88 instrumental deliveries, and these deaths did not occur from the use of the forceps, but from other causes which in themselves necessitated the use of the forceps. Including twelve cases where I have been invited to operate in the practice of other practitioners, I have now used forceps in 100 instances, and I hope soon to make these cases the subject of a special paper.

*Vectis.*—This was in a primipara, in whom the head of a large male child got hitched above the pubes. I intended to use forceps, but the insertion of one blade altered the position of the head, and the labour was completed by the expulsive power of the uterus.

*Malpraxis by Unqualified Attendants.*—Several complications of a very unpleasant nature have occurred from malpraxis of unqualified attendants, in addition to those already incidentally

* The first two cases mentioned under Puerperal Fever, page.
mentioned in this report. One instance occurred where a Sydney midwife came to Newcastle to see that her daughter should be properly attended to at her accouchement. On my arrival, in response to a message, I found that the child had been born five hours, and the placenta was yet undelivered, being retained by irregular contraction, which necessitated its being delivered by the hand. Having done so, I remained with the patient for fully one hour, and then left her comfortable and well bandaged up. It appears that the Sydney midwife did not approve of the Newcastle doctor's practice, for, on returning in about four hours, I found the patient almost moribund, the bandage removed, the uterus distended by a clot of blood larger than a child's head, and the patient's life blood oozing from the vaginal orifice. The mother had carefully removed every bandage the moment my back was turned.

Another case was even more serious; fortunately for the nurse, it occurred in the case of fetus at the sixth month of gestation. At midnight I was hurriedly summoned to a case in the country. The messenger was the woman's husband, and he requested me to bring instruments, as the nurse told him it was a cross-birth. The presentation puzzled me. The os was fully dilated, and protruding through it was a soft pultaceous mass, through the centre of which a movable spiculum of bone protruded. Though the patient's linen was saturated with blood, the pains and intermissions between the pains did not produce those gushes of haemorrhage that would aid in the diagnosis between partial and complete placenta previa. The nurse noticed my perplexity, and handed me something wrapped up in a towel, saying, "I was wiping her and this thing dropped out." Unfolding the towel, I beheld to my horror the mutilated arm of a premature infant that had been torn from its socket. The spiculum of bone proved to be the clavicle. With the aid of a blunt hook, the patient was with much difficulty delivered, the fetus describing a similar revolution to that usually undergone in spontaneous evulsion.

One more case and I shall conclude. One day, as I was passing through a village in the vicinity of Newcastle, I was requested to examine the body of a child said to have been born the previous night, the mother of which was in her ninth labour, and had been attended by three neighbours. Upon inquiry, I found that it must have been either a breech or footling; they said it had come the wrong way first; the labour
had lasted all night, and the poor creature in her sore travail had repeatedly begged that I should be sent for, but had been silenced by the assurance that all was going right. The child was perfectly blue and mottled, with its features swollen, exhibiting all the appearances of having been strangled during birth.

I was uncharitable enough to try and get these three honest women into trouble by sending them to the District Registrar to register the birth and death of their miserable victim, but my artful manoeuvre signally failed. I had hoped that the Registrar would refer them to the Coroner, and that an inquest would ventilate the matter; but the Registrar has no power to register still births, and I am told that it is not within the province of the Coroner to hold inquests upon stillborn children.

THE STATISTICS OF HYDATID DISEASE IN THE AUSTRALIAN COLONIES.

By John Davies Thomas, M.D. Lond., F.R.C.S. Eng.
One of the Honorary Medical Officers of the Adelaide Hospital.

(Continued from p. 252.)

HYDATID DISEASE IN NEW ZEALAND.

Returns were supplied from the following hospitals:—Auckland, Charlestown, Dunedin, Gisborne, Hokitika, Lawrence, Napier, Naseby, Nelson, New Plymouth, Oamaru, Picton, Reefton, Timaru, Wakatipu, Wellington, as follows. No returns have as yet been received from Christchurch, Clyde, Greymouth, Invercargill, Ross, Thames, Wanganui, and Westport.

AUCKLAND GENERAL HOSPITAL.

This hospital has been in existence for over 32 years, and has 80 beds. The average number of in-patients daily, as given by Mr. Roberts' report, is—Males, 58; females, 12. There are no out-patients. Dr. McPherson reports that during the 21 years of his service at this institution he met with but one case of hydatid disease; here the liver was the organ affected.

THE CHARLESTOWN HOSPITAL.

In existence for 13 years. Number of beds, 8. Average number of in-patients daily—males, 5½; females, nil; number of cases of hydatid disease, nil.
THE DUNEDIN GENERAL HOSPITAL.

In existence for 27 years. Number of beds, 190. Average number of in-patients daily—males, 135; females, 32. Mr. A. Burns, the secretary of the hospital, reports as follows:—Cases of hydatid disease treated during the years 1862 to 1879 inclusive (from the hospital records for 17 years) :—Class A: single cysts—Liver—Males, 6; females, 1; total, 7. Relieved, 3; died, 2; result unknown, 2. Kidney—Males, nil; females, 2; cured, 1; died, 1. Uterus*—Females, 1; cured, 1. Class B: Multiple cysts—In liver only—Males, 4; females, nil; total, 4. Cured, 1; relieved, 1; died 2. Liver and elsewhere in abdomen†—Males, 1; females, 2; total, 3. Relieved, 1; died, 2. Thus there were in all 17 cases under treatment, of which there were 11 males and 6 females (including the doubtful uterine case). Cured 3; relieved 5; died, 7; result unknown, 2.

GISBORNE HOSPITAL, WAIRAPARA.

This hospital was founded in 1878, and Dr. Pollen reports on June 2nd, 1880, that, up to that date, no case of hydatid disease had been admitted into the hospital.

THE HOKITIKA HOSPITAL.

Established about 13 years. Number of beds, 48. Average number of patients daily—males, 28; females, 8; total, 36. The hydatid returns extend over the years 1871 to 1879 inclusive. Mr. James reports as follows:—Class A: single cysts, nil. Class B: multiple cysts—In liver only—males, 1; females, 1 (?). Liver and lung—male, 1. He adds—"The female case is entered as cured, but the diagnosis seems to have been extremely vague. The male case died unrelieved. The case of liver and lung was under my care, and was treated by free incision. On admission, suppuration had set in, with irritative fever. Fifty-three ounces of pus and daughter cysts, with hydatid membrane, were brought at once, and during the first six days the quantity of discharge amounted to upwards of 110 ounces. The patient lived for many months, but died eventually."

* It appears probable that this case was one of hydatidigenous degeneration of the ovum (hydatid mole). Recognising the rarity of echinococcus invading the uterus, no case can be fairly acknowledged as such unless the diagnosis be verified by post-mortem examination or operation.
† i.e., elsewhere than in spleen, kidneys, omentum, uterine, or ovary.
THE LAWRENCE GENERAL HOSPITAL.

In existence about 16 years. Number of beds, 30. Average number of in-patients daily—males, 8; females, 2. Mr. Stirling reports that, as far as he knows, no cases of hydatid disease have been treated in this hospital.

THE NAPIER GENERAL HOSPITAL.

Established about 19 years. Number of beds, 21. Dr. Hitchings reports—"No record of any case of hydatid disease in the hospital case book for the last 20 years."

THE NASEBY HOSPITAL.

Founded in 1872, i.e., 8 years since. Number of beds, 12. Average number of patients daily throughout the year—males, 4; females, 1. Dr. Whitton reports as follows:—"There has been no case of hydatid disease in this hospital during the time that I have been surgeon, viz., from 1875; neither do I find any mention of a case in the case-book of the previous surgeon, who took charge of the institution in the year of its erection in 1872."

THE NELSON GENERAL HOSPITAL.

The returns supplied to me include the term of 20 years, viz., from 1859 to 1879.* Number of beds, 68. Average number of in-patients daily throughout the year—males, 22; females, 6. Dr. Boor reports the following cases of hydatid disease:—Class A: single cysts—Liver—Male, 1; female, 1; total, 2. Cured, 2. The female patient was the wife of a farmer; the male a fireman on a coasting steamer.

THE NEW PLYMOUTH HOSPITAL.

According to Roberts,† this institution had in 1878 been only 8 years established; but the returns supplied by Dr. Carroll extend over the period 1866 to 1879 inclusive, i.e., for 14 years. The hospital contains 13 beds. Average number of in-patients daily throughout the year—males, 11; females, 1. Dr. Carroll writes that no other records are on hand than the case-book during his own term of office (for three years), what he can remember as assistant-surgeon prior to that time, and the ordinary hospital roll, which states the nature of the diseases from which

* According to Mr. Roberts' report on Colonial Hospitals, this hospital was in existence only eight years when the data were supplied to him.

the patients suffered. Dr. Carroll therefore cannot guarantee the exact truth of the record of hydatids subjoined. Class A: single cysts—Liver—Males, 3; females, 2; total 5. Relieved, 3; unrelieved, 1; result unknown, 1. Spleen—Female, 1; total, 1. Not relieved, 1. Omentum—Female, 1; total, 1. Relieved, 1. Uterus*—Females, 3; total. Not relieved, 2; result unknown, 1. Ovary†—Female, 1; total, 1; relieved, 1. In the abdominal cavity (elsewhere than in the liver, spleen, kidney, omentum, uterus, or ovary)—Female, 1; total, 1; relieved, 1. Brain—Male, 1; total, 1; died, 1. Spinal cord—Male, 1; total, 1; died, 1. Class B: multiple cysts—In Liver and Lung—Males, 2; female, 1; total, 3. Cured, 1; relieved, 2. Liver and elsewhere in Abdomen‡—Females, 3; total, 3. Relieved, 1; unrelieved, 2. One was reported by Dr. Carroll to be dying at the time the return was supplied, suffering from multilocular cysts, ovaries and omentum. Patient had been tapped 17 times, and would not consent to further tapping. “At the last tapping, seven cysts partially let out.”

THE OAMARU HOSPITAL.

Established about 7 years. Number of beds, 16. Average number of in-patients daily throughout the year—males, 3, females, 1. Mr. Wait, the medical superintendent, reports:—“There has not been a case of hydatid disease in this hospital since it was built.”

THE PICTON HOSPITAL.

In existence 12 years. Number of beds, 17. Average number of in-patients daily throughout the year—males, 6; females (?). Mr. Charles Scott reports:—“There has not been a case of hydatid disease during my term of office (2 years), nor can I find any recorded by my predecessors.”

THE REeftON HOSPITAL.

The records extend from 1872 to 1879 inclusive. Number of beds, 8. Average number of in-patients daily throughout the year—males, 4; females, 2. Mr. David O. Preshaw, the house

* In this case probably hydatid mole is meant.
† Recognising the rarity of true hydatid cysts of the ovary, and the difficulty of arriving at a reliable diagnosis of such cases without operation or post-mortem examination, this case must be held to be doubtful.
‡ i.e., elsewhere than in spleen, kidney, omentum, uterus, or ovary.
A steward, reports:—"Having been connected with this hospital since its institution, and having the records in my charge, I am in a position to state that there has not been a single case of hydatids treated during that time."

**THE TIMARU HOSPITAL.**

Established about 9 years. Returns extend from 1870 to 1879 inclusive. Number of beds, 38. Average number of in-patients daily throughout the year—males, 21; females, 5. No record whatever in the hospital case-book of hydatid disease.

**THE WAKATIPA HOSPITAL.**

The records extend from 1863 to 1879 inclusive. During this period 825 persons were treated as in-patients. Cases of hydatid disease:—Class A: single cysts—Liver—Male, 1; female, 1; total, 2. Cured 1; died, 1. In the subcutaneous tissue—Females, 4; total, 4. Cured, 4. In this case it is remarkable that although there were only two cases of liver hydatids, there were four of cysts in the subcutaneous cellular tissue; possibly this may have been intended for four cysts in one person, not one cyst in four persons. The cases, however, are entered in the space allotted to single cysts.

**THE WELLINGTON HOSPITAL.**

Established over a quarter of a century. Number of beds, 50. Average number of in-patients daily throughout the year—males, 40; females, 6. The records supplied extend from 1863 to 1879 inclusive. Dr. Gore Gillon states—"I have been in this hospital for 16 months only, and as it has only of late had a large number of patients, the records are necessarily defective. The cases quoted are all those known to have occurred, though probably others may have been forgotten." These are as below:—Class A: single cysts—Liver—Male, 1; female, 1; total, 2; cured, 1; relieved, 1. Kidney—Male, 1; total, 1; died, 1. Lung—Male, 1; total, 1; died, 1.
Medical Society of Victoria.

ORDINARY MONTHLY MEETING.

WEDNESDAY, AUGUST 3, 1881.

(Hall of the Society, 8 p.m.)

Present: Dr. James Robertson, Dr. Hewlett, Dr. Moloney, Dr. A. Black, Dr. Sparrow, Dr. Harricks, Mr. R. Robertson, Mr. Gray, Mr. W. Barker, Dr. Rowan, Mr. Webb, Dr. Balls-Headley, Dr. J. D. Thomas, The Baron von Mueller, and Dr. Williams.

Dr. Walsh was present as a visitor.

The Vice-President, Dr. Hewlett, occupied the chair.

The minutes of the last meeting were read and confirmed.

The names of two gentlemen were proposed as ordinary members.

The following papers were then read:

I.—AN ACCOUNT OF A CASE OF SUDDEN DEATH FROM HÆMOPTYSIS, IN CONSEQUENCE OF THE RUPTURE OF AN ANEURISM OF A BRANCH OF THE PULMONARY ARTERY, WITH REMARKS ON SIMILAR FORMATIONS.

By John Williams, M.D.

Physician to the Melbourne Hospital.

At a recent meeting of the Medical Society, I exhibited a lung removed from a phthisical patient, who had died suddenly from haemoptysis, in consequence of the rupture of an aneurism of a branch of the pulmonary artery, and at the request of some of the members, I to-night present a report of the case, with some remarks on similar formations.

The history of case was as follows:

George B., aged 28, a hotel waiter, was admitted into the Melbourne Hospital under my care, on March 10th, 1881. He stated that he had always enjoyed good health until two years ago, when he caught a cold, accompanied with cough and expectoration, which has continued more or less ever since. Six months ago he commenced to lose flesh. He has never had haemoptysis.

On admission, he is considerably emaciated, and complains of cough, expectoration, night sweats, diarrhoea, and loss of strength. The left side of the chest is much flattened, the respiratory movements are impaired, there is dulness on percussion, and loud
sibilant and moist râles are heard all over the left lung. On the right side the resonance and vesicular murmur is variable and patchy, and sibilant rhonchi are heard generally.

On April 4th it is noted that the diarrhœa was relieved, but the cough continues troublesome. He continued in much the same state until the night of May 8th, when a severe attack of hæmoptysis occurred. The quantity of blood expectorated was estimated at over a pint. He was treated with ice, hst. magnes., sulph. acid and ergot. He continued to spit up blood in small quantities, principally small clots, until May 8th, when another rather smart attack occurred. During the next few days it persisted to a slight extent, and had very nearly stopped altogether on May 23rd. On May 24th, at 1.30 a.m., a sudden profuse attack of hæmoptysis came on, and he died, apparently suffocated, in a few minutes. The time elapsing between the first attack of hæmoptysis and the fatal one was 16 days.

I am indebted to Dr. Allen for the following notes of the autopsy:

Body pale and emaciated.

Heart.—Valves normal, left ventricle feebly contracted, the right relaxed.

Lungs.—The left lung was everywhere bound to the chest wall by old membranous adhesions, the visceral pleura being greatly thickened. The lung substance was tough and fibroid, the cut surface being studded with dilated bronchial tubes, which sometimes formed distinct cavities of small size; the intervening tissue was grey or slightly pigmented, and dotted here and there with minute miliary tubercles. The bronchi and bronchial tubes were full of frothy blood, which came from a cavity the size of a walnut, situated close to the outer convex surface of the lower lobe, about two inches from the extreme base. This cavity was lined by a thick firm layer of indistinctly-laminated, partly decolorised, fibrinous clot; this clot was accurately adjusted to the wall of the cavity, from which it could for the most part be easily shelled out; but at the deep extremity of the cavity, the compact fibrinous sac opened by a rounded orifice, over two lines in diameter, into a thin-walled, pouche dilatation of a considerable branch of the pulmonary artery. This dilatation was about the size of a large pea, and contained no clot; immediately before dilating into this pouche sac, the artery gave off some branches to the surrounding lung tissue, and another which divided into more
or less dilated branches in the fibrous wall of the larger cavity. After passing the aneurism, the artery sent some branches onwards to the pulmonary tissue, and others into the wall of the cavity on the distal side. Where the small dilatation of the artery opened into the larger sac of fibrin, the inner coats of the artery ceased abruptly, while the outer coat was prolonged for at least a short distance on to the larger secondary sac.

The old phthisical cavity had originally opened pretty freely into a bronchial tube close to the primary aneurism, but the formation of the secondary aneurism rapidly destroyed this communication. The fatal rupture took place, not in the secondary aneurism, which was supported by the wall of the old cavity and by its own layers of fibrin, but in the thin-walled primary aneurism, close to its junction with the secondary sac. The extravasated blood burrowed a little distance into the lung substance before finding at last a free exit along the bronchial tube.

The right lung contained numerous groups of grey, hard, miliary tubercles, irregularly scattered through its substance. At the base of the upper lobe there were a number of cheesy patches, some dry and friable, others commencing to soften, surrounded by great numbers of grey miliary tubercles, so as to form a belt of consolidation stretching continuously across the centre of the lung. The bronchial tubes contained a considerable quantity of blood, which had come from the other lung, and had been inhaled into some of the ultimate tubes and air vesicles, so as to produce small purplish spots on the surface of the lung, underneath the pleura.

**Bronchial glands.**—Large, darkly-pigmented, and thickly dotted with miliary tubercles.

**Liver.**—Slightly fatty.

**Spleen.**—Large, not pulpy.

**Kidneys.**—Capsule somewhat adherent, surface slightly granular, cortices streaky on section.

**Stomach and Esophagus.**—Full of blood, partly fluid, partly clotted, and largely mixed with air-bubbles. There was no breach of surface in the mucous membrane. The oesophageal glands were enlarged and opaque.

**Intestines.**—There was extensive ulceration of the caecum and its appendix; the ulcers were very large, with opaque granular bases, and thickened, irregular edges. Small ulcers of similar character were scattered along the colon. Peyer's patches, near the ileo-caecal valve, were swollen, but not ulcerated.
The principal points of the foregoing case, therefore, were, first, the existence of long-standing fibroid phthisis and the formation of a firm-walled cavity; a branch of the pulmonary artery running along the deep side of the cavity bulged gradually into it, forming a small sacculated primary aneurism; other twigs of the same artery running in the wall of the cavity also became slightly dilated. After a time, the inner coats of the primary aneurism ruptured, and the outer coat yielded to the blood pressure, forming a secondary saccular aneurism, which became lined with fibrinous clot, and enlarged till it moulded itself accurately upon the inner surface of the phthisical cavity. As the aneurism enlarged, the prolongation of the outer coat over it became thinned, and at last disappeared. At this stage, therefore, there was a thin-walled small primary aneurism, destitute of clot, and a large secondary saccular aneurism, whose walls were formed of firm fibrin, and were further supported by the firm fibrous membrane lining the old phthisical cavity. Hence it followed that the strong secondary aneurism did not give way, the fatal rupture occurring, as before stated, in the primary dilatation of the artery, close to the neck of the secondary sac.

The existence of aneurisms in connection with branches of the pulmonary artery traversing the walls of phthisical cavities in the lungs, and their rupture as a cause of fatal hæmoptysis, has only been recognised within comparatively recent times, although it is very probable that they are not uncommon. One of the first cases, if not the first case recorded in Great Britain, is reported by Mr. Fearn, of Derby, in the Lancet of 1841. Since then Drs. Peacock, Cotton, Quain, Moxon, and others have published similar ones. Rokitanski has recognised the condition, but it is to Dr. Rasmussen of Copenhagen, and Dr. Douglass Powell of London, that we are indebted for our present knowledge of such formations and the conditions under which they are liable to occur.

Aneurisms of branches of the pulmonary artery consist of a dilatation of their coats. They differ in shape according as to whether the vessel in which they occur traverses the wall of a cavity, or crosses it imbedded in a trabecula. In the former case the dilatation is one-sided, and in the latter fusiform. Dr. Rasmussen is of opinion that every cavity in the lungs, the walls of which are formed by a compressed pulmonary tissue containing non-obliterated vessels, may become the seat of such dilatations, with succeeding hæmorrhage; yet the thin-walled
cavities immediately abutting upon air containing pulmonary tissue seem most frequently to become the seat of these vascular extensions.

Dr. Powell, for the purpose of noting the kind of cases in which these formations occur, divides cavities into "old standing quiescent," "old standing active," and "recent" cavities, and he considers that they are most frequent in the former, and rarely developed in the latter.

There is nothing in common between the aneurisms I am describing and aneurisms of the systemic arteries. The cause of the formation of pulmonary aneurism is not an atheromatous change in the wall of the vessel, but consists principally in the want of support to that wall of the vessel which is directed towards the interior of the cavity, and in the heightened intravascular pressure brought about by the obliteration of so many of the branches of the pulmonary artery in the neighbourhood, aided probably by the aspiration of the blood during fits of coughing. These aneurisms are sometimes single, more frequently multiple. They vary in size from that of a small pea to that of a Maltese orange. Their walls are generally thin and friable. The wall of the vessel, at its bulged portion, is usually greatly thickened, though more brittle than natural. Dr. Rasmussen describes this thickening as due to hypertrophy of the muscular coat of the artery, but Dr. Powell thinks that the coat is thickened by inflammatory change, set up by the increased strain upon the wall, as it is the exposed wall only which is so affected. The first attack of haemoptysis is rarely fatal; generally, as in the case I have narrated, there are several attacks of haemorrhage at irregular intervals before the fatal one.

The specimen which I am exhibiting differs in some respects from cases hitherto published, inasmuch as there appears to be a secondary aneurism composed of thick fibrinous walls formed in connection with rupture of the dilatation or primary aneurism.

II.—ON A CASE OF EPITHELIOMA OF THE RECTUM—REMOVAL—RECOVERY.

By W. Balls-Headley, M.A., M.D. Cantab.

Hon. Physician Melbourne Lying-in Hospital.

Mrs. C., aged 47, a bright complexioned healthy-looking woman was admitted to the Lying-in Hospital on November 25, 1881.
Patient says she was quite well up to a year previously, when at closet she first noticed a lump at the back passage. Had lost a little blood and some offensive discharge. Had not got thinner. This lump had steadily increased in size. She then complained much of the lump, of constipation, of great smarting burning pain at the anus, constant, but greatly increased on defecation, and so lasting for hours afterwards. The father died of cancer of the hand. The mother of cancer of the uterus.

On examination, there was found a tongue-like mass an inch long, and perforated in three places, projecting from the posterior half-circle of the anus, to which it was attached. Within the anus, the posterior half of the rectum was thickened and ulcerated to a distance of 2\(\frac{1}{2}\) inches upwards, above which two glands could be felt enlarged. The posterior rectal wall was not adherent to the subjacent tissue. The anterior rectal wall was healthy. All other organs were healthy, and no other enlarged glands discovered. Microscopically the tissue was composed of epithelial cells of various sizes and shapes, easily separating, with one and more nuclei.

On November 25, the patient, having been previously prepared, was anaesthetised, and the finger, having been introduced into the rectum, guarded the point of a bistoury till it was thrust through the rectal tissue and skin, emerging at a point just anterior to the coccyx; the intervening tissue was at once divided by it in the median line. Commencing from this incision, and a good half-inch from the extreme external edge of the disease, an elliptical incision was then made extending to a little short of the median line of the recto-vaginal septum, the knife being carried at once deep into the fat of the ischio-rectal fossa. A similar incision was made on the other side. This part of the rectum was then separated from the subjacent tissue, chiefly with the finger, the attachment of the levator ani being divided with the scissors. A probe pointed thread-catcher was passed from the anterior part of the wound through the already divided subjacent tissue well up above the level of the disease, and then through the antero-lateral rectal wall, and by this means an écraseur wire was drawn through, and the lateral wall of the rectum thereby divided; similarly the other side. A rectangular flap, containing the whole mass of the disease, and sufficient healthy tissue was thus attached only above, which was then pulled down and divided by the écraseur. The hæmorrhage was unimportant. The wound was syringed with
weak carbolic lotion, no dressing nor sutures were applied. The chasm made was huge.

The relief to pain was immediate. After two days, weak carbolic injections were frequently employed, and the patient recovered without a bad symptom. A teaspoonful of castor oil was found to be a full purgative dose.

The patient was discharged on Jan. 31 with the wound healing rapidly. There was no control over the bowel, but she was quite comfortable, and the bowels acted regularly—thus causing scarcely any discomfort.

May 21, 1881.—Since the operation, six months ago, she has been perfectly free from pain and discomfort, except that if her stools are loose she has no control. Usually the bowels act comfortably. Wind passes without restraint. She has got very fat, has no pain, and is happy, and contented in her mind. Examination shows that the anus is now somewhat higher than previously, and is lined internally by mucous membrane, as though the mucous membrane had been somewhat stretched downwards, and the skin drawn a little upwards. There yet remains half-an-inch of raw, healthy granulations, external to the anus. The anus admits the first finger up to the second joint, or a No. 4 rectum bougie easily, a No. 5 tightly. There is no trace of a return of the disease. She is directed to take a No. 4 bougie with her, and pass it according to circumstances.

DR. MOLONEY would like Dr. Williams to have dwelt more minutely on the differential diagnosis of such cases. It would not perhaps be impossible to localise the hemorrhagic place by auscultation, if, as in this instance, the aneurism lay on or near the surface. It would be interesting to know if the bleedings had any connection with the state of the barometer, as it had been asserted that atmospheric conditions controlled very greatly attacks of hemorrhage. Some time ago a paper appeared in the Lancet on this subject, but the author concluded, from repeated observations, that the state of the atmosphere had little, if anything, to do with hæmoptysis or other forms of hemorrhage. The subject, however, deserves fuller inquiry.

DR. JAMES ROBERTSON thought it would be difficult to make a diagnosis during life. He had never seen a case exactly similar to the one described by Dr. Williams. There were certain points that might be taken into consideration. It would not be likely to occur
in the early stage of phthisis. It was more probable as a cause of haemorrhage in the cavities of old chronic, and more especially fibroid phthisis. With regard to treatment, he did not think anything more could be done than had been in the present case, and in any case it would prove fatal sooner or later. He did not catch from Dr. Williams' remarks if the ice used had been sucked or applied externally. He had found the latter plan sometimes beneficial.

Dr. Williams, in reply, stated that the aneurism was not diagnosed during life, and he thought even if the formation was large enough to produce an audible bruit, which he much doubted, the loud râles all over the chest would have prevented its being distinguishable by auscultation. In reply to Dr. Robertson, he stated that the ice was administered by the mouth, as in consequence of the profuseness of the haemorrhage the blood had been sucked into the lungs in all directions, producing crepitant râles everywhere, and thereby rendering it impossible to ascertain the exact locality of the rupture, or even which lung was concerned. He looked upon the disease as important from a pathological point of view, and the possibility of the existence of such formations should be borne in mind in forming a prognosis of hemoptysis which comes on at a late stage of long standing lung disease.

Remarks.—The operation was introduced by Morgagni, established by Lisfranc in 1830, practised by Velpeau and Recamnier, Chassaignac and Maisonneuve. In England it was revised by Sir James Paget, Allingham, Gay, Holt, and Holmes, and a treatise was published by Cripps in 1880, to which Holmes specially refers.

Of the prognosis of the operation. Out of 66 cases 11 died, being 17 per cent. Of the 11 deaths, 7 were from peritonitis, of which it was known that in 3 the peritoneal cavity was opened.

Of the prognosis of recurrence of disease. Out of 36 cases, there was no recurrence in 16 cases in from a few months to over four years, being 44 per cent.; in 20 there was recurrence; in some so slight as that it was doubtful if the disease was originally completely removed, and extirpation was easy, giving apparently permanent relief; in the remainder of this 20 a general cancerous cachexia occurred.

The advantages of the after effects after non-fatal operation
Aet. 15, 1881 Australian Medical Journal.

are—removal of pain and anxiety, chance of life, non-return of the disease after lengthened periods in 44 per cent.

The apparent disadvantages are: 1. The mortality of the operation—17 per cent., reducible to 13 per cent. if the peritoneal cavity be not opened, and this probably to be greatly reduced by experience; without operation, all must die. 2. Contraction of the rectum, or incontinence of faeces, relievable by treatment, one or other being certain to occur were the disease left untouched.

The cases suitable for operation are only those in which the whole disease can be certainly and safely eradicated.

In the after treatment, to avoid blood-poisoning, free opportunity for discharge should be given, by omitting pluggings and dressings, while sutures are worse than useless.

Dr. Webb could not take such a favourable view of the operation as Dr. Balls-Headley. He (Dr. Webb) had once seen a man who had been operated on who could not afterwards hold his faeces, and the inconvenience was so great, that had he lived, it was proposed to have colotomy performed to relieve his condition. He died a month after the operation.

Dr. Balls-Headley, in reply, stated that his patient could retain her stools. There was great relaxation in these cases at first, but later on the tendency was to too great contraction. Dr. Webb's case had probably not lived long enough to arrive at contraction.

EXHIBIT.

Dr. W. B. Walsh, of Kew, exhibited a whistle which had been swallowed and passed through the intestinal canal of a child; and he has since furnished the following notes of the case:—

On Tuesday evening, the 26th July, I was sent for to see W. L., a boy of six years of age, who, I was told, "had a whistle stuck in his throat." On my arrival, I found that the patient, a healthy boy, had, whilst playing with a whistle, accidentally swallowed it. My first impulse was to get it back by an emetic, and I accordingly gave the boy a tumbler of mustard and water. This I afterwards regretted, because, although the vomiting it produced was very slight, still it was freely tinged with blood, showing that the foreign body had produced some laceration of the pharynx in its descent. This fact, together with the very conflicting accounts which I received with regard to the size of the whistle, the danger of its being sucked into the larynx during emesis, and finally, my experience of a former case, in which a
penny found its way through the bowels of a boy about the same age, determined me to leave the whistle in the stomach of the child, and allow it to be expelled per anum.

I therefore ordered the mother to watch the stools carefully, and to give the boy a diet of hard-boiled eggs, cheese and rice, in order to produce a good healthy solid motion, and so push the offending body before it, and at the same time protect the coats of the intestine from injury. The parents were somewhat surprised at this line of treatment, as they would have been more inclined to have given the child a dose of castor oil; but a little reasoning soon convinced them of their error. The whistle was expelled per anum without any pain 36 hours after it had been swallowed. It was a smooth, bi-convex disc of tin, perforated in the centre, and measuring 28 millimetres, or a little more than one inch in diameter, and 9 millimetres in thickness.

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**Hospital Reports.**

**LYING-IN HOSPITAL.**

**Case of Ovariotomy—Fatal.**

Under the care of Dr. Rowan.

Reported by Felix Meyer, M.B., Ch.B., Resident Surgeon.

E.M., aged 34, married, was admitted into this institution on the 6th June, 1881, suffering from a tumour of the right ovary.

Patient stated she had been married thirteen years, had had no children, but had a miscarriage some eighteen months after marriage. She had enjoyed good health till six years before admission, when she hurt herself trying to lift a heavy weight. This was followed by metrorrhagia, which continued uninterruptedly for four months. After this ceased she began to swell, and did so gradually up to date of admission.

The chief symptoms complained of were loss of appetite, restless nights, extreme irritability of the bladder, general neuralgic pains, especially in the thighs, and painful, irregular, and excessive menstruation.

She had received medical advice in Tasmania some two years previously to admission, and operation was then recommended, but nothing was done.
On admission her general appearance was unhealthy; the features had a drawn expression. The complexion was sallow, and the body very spare. General temperature of the body below normal. Extremities coldish. Absence of mammary areolae. Catamenia began at the age of twelve and a half, regular and excessive. No history of leucorrhoea. Greatly increased frequency of micturition of late. Urine light coloured, sp. gr. 1020, phosphates, albumen. Abdomen greatly enlarged, more on the right side than the left. Dulness uniform, except over a small space on the left side on a level with the umbilicus, in a line with the axilla. Dulness not altered by position. Area of hepatic dulness increased from above downwards. Tenderness in both hypogastric regions greatly increased on pressure. Tumour freely movable. Fluctuation well marked, ascites, general enlargement of abdominal veins. Uterus latero-verted to right side, and higher up than normal.

The measurements are as follows:—

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Dimensions</th>
</tr>
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<tr>
<td>Girth at umbilical level</td>
<td>41 inches</td>
</tr>
<tr>
<td>From ensiform cartilage to umbilicus</td>
<td>11½ &quot;</td>
</tr>
<tr>
<td>From umbilicus to symphysis pubis</td>
<td>10½ &quot;</td>
</tr>
<tr>
<td>From right anterior superior spine of ilium to umbilicus</td>
<td>15 &quot;</td>
</tr>
<tr>
<td>From left anterior superior spine of ilium to umbilicus</td>
<td>13 &quot;</td>
</tr>
</tbody>
</table>

On the 8th June, 1881, patient was given a hypodermic injection of morphia gr. ¼, atropine gr. ⅛, and shortly after placed under the influence of a mixture of alcohol chloroform and ether.

Dr. Rowan made a longitudinal incision 4 inches long through the integument in the median line, starting three inches below the umbilicus. The subjacent layers were divided in turn and a thin cyst wall met with. This was punctured with a trochar and canula, and a few pints of clear fluid withdrawn. The tumour was then visible, consisting of two main large cysts with numerous other smaller ones. There were some deep adhesions, which were broken through, but there was some difficulty experienced in freeing the tumour from the expanded broad ligament which partly enveloped it.

The main cyst was punctured with trochar and canula and emptied of a large quantity of thick, dark, blood-coloured fluid. The fluid in the smaller cysts was straw-coloured. There was some slight haemorrhage, which was checked by a couple of silk ligatures.

The tumour was drawn through the abdominal opening and an
ordinary sized clamp applied to the pedicle, which was short. The cyst was snipped off and the cut surface of the pedicle touched with solid ferri perchlor. The abdomen was then carefully sponged out with warm carbolic acid lotion, and the wound closed with deep and superficial carbolised sutures. Dry dressing was applied. At the end of the operation the pulse was 72, weak and the temperature normal. A grain opium suppository was given. During the evening crampy pains were complained of, and a hypodermic injection of $\frac{1}{8}$ gr. of morphia was given.

9th June.—At 9 a.m., pulse 108, temp. 99.4, pains complained of. Pil. opii. gr. j. In the evening, the temperature rose to 101.5°, and the pulse to 128. Thirst was complained of, and there was a tendency to vomiting. The patient was fed by nutrient enemata every two hours, and thirst was relieved by ice and champagne.

10th June.—At 5 a.m., vomited bilious matter; the vomiting continued more or less throughout the day. The pulse and temperature kept at about 124 and 102° respectively. Opium was given per rectum.

11th June.—Vomiting continuing slightly. Pulse 135, temp. 102.6° evening. A good deal of tympany of abdomen. A long enema tube carefully passed up the rectum with the effect of giving vent to a lot of gas, which greatly relieved patient. Two lowest sutures were removed to-day. There was slight sanguineo-serous oozing.

The history of the three following days is one of increasing exhaustion, with lowering of temperature and quickening of pulse. Vomiting and tympany were marked symptoms, the latter relieved by the enema tube. The patient retained a large amount of nutriment by frequently repeated enemata, but anything given by the mouth brought on vomiting. She died from exhaustion on the 14th June, at mid-day.

CHILDREN'S HOSPITAL.

Case of Duchenne's Paralysis.

Under the care of W. Snowball, M.B.

Reported by Mr. E. S. Jackson.

J. M., male, 13 years old, born in Ireland, in colony 6 months.

About 4 years ago fell down a sewer, but can give no account of the part of his body he fell on. Says he did not feel it at the time.
About a year after this he noticed that he "rolled about" when he walked, and from that time this symptom has increased. With this he has never had any pain, and no abnormal sensations such as pins and needles. His mother noticed his calves getting larger on examination. He is a well-developed intelligent-looking boy, with a ruddy complexion and body well nourished. His gait is waddling—his body swaying from side to side, and rather more to the left side than the right—his shoulders elevated, his feet put cautiously to the ground, his left foot inverted. He stands with his legs apart, his abdomen protruded, there being a considerable degree of lordosis, his shoulders seemingly somewhat thrown back.

On examining the lower extremities—his thighs appear normal, the skin "marbled" over them. The circumference of each, in the thickest part, 15 inches. His legs appear abnormally developed, measuring 12 ½ inches at the thickest part, and feel firm. This abnormal development is principally caused by the outer belly of the gastrocnemius in each leg, which stands out almost like a tumour. There is no apparent loss of sensation. He can distinguish two pin's points at a distance of less than ½ an inch at any part of his leg. Muscular power greatly diminished. Reflex motion appears to be absent in the lower extremities, patellar and cremaster reflexes being absent. No electro-muscular contractility.

The grasp of either hand is feeble, but he writes steadily, and can pick up small objects readily. The forearm apparently increased in girth, measuring 8 inches in diameter; the measurement round the thickest part of biceps 7 ¾ inches.

When seated upon the floor and asked to rise to the standing position, he does so by placing his hands on the floor, and with his feet well behind his body on the floor, pushing himself up. Having thus raised himself half way, he brings his feet forward a short step or two, and finally completes the operation by raising his body with his left hand on his left knee. When rising from a chair, he does so by supporting his body with his hands on his knees and gradually grasping his thighs from below upwards, so as to raise his body.

He is being treated with Faradization and phosphorus, ½ gr. doses, three times daily.
VICTORIAN MEDICAL BENEVOLENT ASSOCIATION.

The annual meeting of the Association was held on 28th July, in the Hall of the Medical Society. The vice-president, Dr. Jonasson, occupied the chair.

The report of the committee was the first business; this was as follows:—

Gentlemen,—The applications for relief brought before the committee have not been numerous during the past year, but it must be borne in mind that those, so considered, do not by any means represent the whole of the claims that have been preferred, and that, although the committee has met but seldom, its use has been not unfrequently demonstrated in disposing of applications referred to them individually, and in so relieving many members of the profession from importunate solicitations, which, but for such means of reference, would have been complied with, and a practical encouragement given to imposition.

In consequence of the death, removal, and absence of several regular subscribers, the funds have, to some extent, suffered; but as there are, on the other hand, several new subscribers, the whole amount will not compare very unfavourably with that of former years. The permanent fund of the Association now reaches to the sum of £1380, and it will be necessary to make fresh arrangements with reference to its investment. The increasingly-large amount which the permanent fund now represents, has very naturally suggested to your committee the need of care in this particular. At one of the meetings this subject was brought under discussion, and, without referring to the particular reasons out of which the discussion arose, it was then, after careful consideration, resolved that for the future the funds of the Association be invested only in Government securities.

The objections occasionally offered to the Association, that it is not an urgently required institution, as is shown by the comparatively few applications made for relief, must be met by the reply given on former similar occasions, that its usefulness will find its complete demonstration in the future, when the number of widows and orphans will in all probability be much greater than now, and when a permanent and certain income will, in consequence, be required. From this point of view, the permanent fund must be looked upon as a provision that may eventually grow into much larger proportions, to be available when the need
of its existence shall be a great deal more apparent than at present.

Among the deaths of subscribers to the fund, must be mentioned, especially, that of Dr. Day, who from the first was a warm supporter of the Association. Your committee desire to add their testimony to the many expressions placed on record of the great loss sustained by the profession through his death. The obituary includes also Dr. Carr, who was a steady subscriber for many years, and Dr. W. Molloy, who had contributed regularly since his arrival in the colony.

Your committee have met three times, the attendance being as follows:—Mr. Gillbee 1, Dr. Jonasson 2, Mr. Rudall 1, Dr. Cutts 2, Dr. Neild 3, Dr. Graham 2, Mr. Gray 2, Dr. McMillan 2, Dr. Ryan 3, Dr. Jamieson 2, Mr. Fitzgerald 0. The following cases have been dealt with:—

**Case 1.** The widow of a medical man—she having been twice previously assisted—applied for further aid, to meet some requirements in her business. On inquiry, however, it was found that there were no reasons of a sufficiently satisfying kind to warrant a renewal of assistance, and the application was, therefore, refused, save to the extent of a small sum which the treasurer had advanced on emergency.

**Case 2.** A small sum was granted to the widow of a medical man, this being the eleventh occasion upon which she had been relieved. The case, however, was considered particularly deserving, the applicant being old and nearly blind.

**Case 3.** The friends of an L.R.C.S. Ed., long resident in New Zealand, but who, many years ago, had practised in Victoria, applied for a contribution towards a fund which was being raised in Dunedin for the benefit of his widow and children. The sum of ten pounds was granted.

**Case 4.** The widow of a medical man who formerly practised in Geelong, and who, five years ago, made an unsuccessful application for relief, renewed her application. The investigation into the case, at that time, showed the applicant to be undeserving, and this, the latest, application therefore was refused for the same reasons as those which influenced the committee in the first instance.

**Case 5.** An M.R.C.S. Eng. (1830), who had once practised with much success on one of the principal goldfields, but who had suffered ruinous reverses, was granted ten pounds to enable him
to procure some necessaries for the purpose of taking, temporarily, the duties of a medical man in the country.

CASE 6. Two pounds were given as temporary relief to the son of an eminent physician, whose name is well-known in connection with the medical literature of the old country.

The Treasurer's Report followed, as under:

_The Treasurer in account with Victorian Medical Benevolent Association._

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**CAPITAL ACCOUNT.**

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These were adopted after some unimportant explanation by the Treasurer.

The election of Officers for the ensuing year then took place, with the subjoined result:

President: Mr. Gillbee. Vice-Presidents: Dr. Jonasson, Mr. Rudall. Honorary Treasurer: Dr. Cutts. Honorary Secretaries: Dr. Neild, Dr. Graham. Members of Committee: Mr. Gray, Dr. McMillan, Dr. J. P. Ryan, Dr. Jamieson. Trustees: Dr. Cutts, Mr. Gillbee, Mr. Fitzgerald. Auditors: Dr. Kirkland, Dr. Browning.
The List of Subscribers of One Guinea for 1880-81 was announced by the Treasurer as herewith:

Adam, Rothwell
Annand, G.
Balls-Headley, W.
Barton, F. (2 years)
Beaney, J. G.
Barker, E.
Barker, W.
Barrett, J.
Bird, S. D.
Brownless, A. C.
Burke, S. J.
Carstairs, J. G.
Casey, C. G.
Cook, J.
Cutts, W. H.
Dick, T. T.
Dowling, F. J.
Duret, C.
Fetherston, G. H.
Fishbourne, J. W. Y.
Ford, F. T. W.
Fisher, A.
Fitzgerald, T. N.
Fletcher, E.
Francis, H.
Fyffe, B.
Gillbee, W.
Grace, J. F.
Graham, G.
Gibson, J.
Gray, A. S.
Haig, W.
Heath, R.
Hewlett, T.
Henry, D.
Hora, Tudor
Jakins, W. V.
James, E. M.
Jamieson, J.
Jonasson, N.
Kirkland, J. D.
Le Fevre, G.
Lewellin, J. H. H.
Long, D. R.
MacGillivray, P. H.
MacInerney, J. R.
M'Crea, W.
McMillan, T. L.
Moloney, P.
Morrison, A.
Motherwell, J. B.
Neill, J. E.
O'Hara, H. L.
Paley, E.
Penfold, O.
Pestell, J.
Pinnock, R. D.
Pincott, R.
Robertson, J.
Robinson, R.
Robinson, S. R.
Ronald, W.
Rudall, J. T.
Ryan, C.
Ryan, J. P.
Shields, A.
Smith, M.
Smith, C.
Smith, L. L.
Snowball, W.
Telbot, R.
Turner, D.
Webb, J. H.
Whitcombe, W. P.
Wooldridge, H.
(2 years.)
Williams, D. J.
Williams, J.
Wilkie, D. E.
Wilson, H. B.

A conversation took place as to the expediency of marking the progress of the Association by means of a dinner. It was remarked, as something unusual, that during the whole sixteen years that the Association had been in existence, there had been no gathering of this nature by its supporters. It was therefore resolved that Drs. Neild, Jonasson, and J. P. Ryan be a subcommittee to take the necessary steps for bringing the subscribers together to dinner.

THE WATER SUPPLY OF MELBOURNE.

It is satisfactory to learn that at last some active steps are being taken to deal effectively with the question of Metropolitan Water Supply. The official report published in the daily papers of the 2nd instant shows that the Yan Yean bids fair to be as dirty and as fetid next summer as it was last; moreover, should the drought continue through the winter of 1882, the supply for the following hot season
would be wholly inadequate, and we would be, as the *Argus* remarks, within measurable distance of a great calamity. The history of the years 1867-9 shows that such an occurrence is by no means impossible, and hence the necessity for immediate action.

It is now proposed to divert into the Plenty watershed two creeks which at present run northwards to the Goulburn, and to carry the Plenty water, thus reinforced, from the base of the mountains to the reservoir along a high-level covered channel. Thus it is claimed that at an outlay of £224,000 we can secure a constant and abundant stream of clear cold water into the reservoir. If this were possible, all complaint of scarcity, discoloration, or smell would soon be removed. We regret, however, to find how little is known about the watercourses in which Melbourne is most vitally interested. Of the two creeks now specially referred to, we owe all our exact information to a trial survey conducted during the present winter. Within that season their flow has varied from 16 to 50 million gallons a day, and in face of such a fact it is impossible to judge what may be their condition during summer. The permanent survey now in progress will last only two months, and can therefore throw no light on this point. Should the summer flow be small, the hope of preventing stagnation during the hot weather will be vain, and the water may become as offensive as before, though the storage of the winter rains would prevent any scarcity of supply. We regret that expensive works must as a matter of urgency be carried out upon such imperfect data.

The chief engineer of Melbourne Water Supply is still of opinion that recourse must finally be had to the Watts and its tributaries; and he very properly insists that the whole watershed of this river should be permanently reserved. Not long ago large areas of splendid forest country upon the Black Spur were sold by auction. We hope that the Government will promptly put an end to such a short-sighted policy, and where possible will resume possession of the land thus alienated.
It must be remembered that none of the water from the northern creeks will be available for at least fourteen months, and householders should take timely warning that the Yan Yean will, in all probability, be scanty and bad in quality during the coming summer; we therefore strongly urge them to provide for their own requirements by storing as much rain water as possible in suitable tanks. The authorities, too, will do well to strictly prevent the waste which undoubtedly occurs at present; and, finally, we would express the hope that now at least some thorough examination will be made of all the streams which may possibly be concerned in the metropolitan water supply.

IMPORTED FISH.

The importance of care in the manipulation of fish, especially when intended for so long a journey as from England hither, should by this have strongly impressed the fishmongers in both countries. It is by no means generally understood either by the public, who may be pardoned for their ignorance, or by fishermen (amateur or professional), or fish-dealers, that that valuable dietary requires the tenderest handling, and those who have witnessed the rough transhipment of fish at the Gippsland Lakes, and the mauling and knocking about they receive on auction mornings at the Fish Market, can feel no wonder at the poorness of flavour so commonly experienced at our dinner tables. The flesh of fish it is well known is rich in phosphorus, and this combined with easy digestibility makes its value as an article of food, especially in conditions associated with nervous exhaustion. Phosphorus compounds, however, are the commonest and earliest products of decomposition, and substances full of that chemical are readily perishable, more particularly when disintegration is furthered by bruising and shaking. Fish in fact begin to decompose immediately after death, and should be handed over to the cook, as even the common fish-hawker has an inkling of, as nearly as possible “all alive oh!”

It is a common medical experience that numerous
families possess an actually hereditary inability to digest fish, and it has been assumed, on the principle of what is one man's meat is another's poison, that among those so afflicted fish-eating should be tabooed. It is, however, demonstrable that this fish-dyspepsia is mainly, if not entirely, owing to a very delicate appreciation by such stomachs of the beginning of piscine decay, just as phosphorus, now so fashionable and effective a remedy, is so intolerable to many constitutions, even where its use is strongly indicated. There are very few who cannot enjoy a fish meal by the sea-side, where it is presented fresh and not decomposing. The exacting summer visitors of the marine resorts along our bay, for instance, find the commonly despised flathead glorified by its freshness, and a crisp, curd-like savoury diatetic. The explanation then of the difference in the savour and digestibility of the same species of English imported fish will be found in the time elapsing between the catching and death of the fish, and their refrigeration. The sooner they find their way to the ice-chamber the better, as a longer time means more frequent handling, which is always rough, and a greater advance, not appreciable till the meal is made, in decomposition. If then the fish trade between the home countries and here is to assume, as it should, a great importance, it will be found necessary to transfer fish at once after catching into refrigerating chambers on board boats or vessels specially constructed for the purpose. The contradictory letters of several correspondents in the *Argus* really go to prove that the method of thawing or preparation for cooking is not significant, provided the fish have fair play before being frozen.

The successful consignments of exported Australian meat owe that success more to the earliness of refrigeration after death than to any other cause, and when importers and exporters at either terminus are properly possessed with a nice appreciation of the care and delicacy necessary in the digestible treatment of perishable articles of diet, we may, with antipodeal friends, enjoy in common the good things of opposite ends of the earth.

Dr. W. B. Carpenter, in his *Animal Physiology*, states
that "fishes are occasionally found embedded in the ice of the Arctic seas, and some of these have been known to revive when thawed." Fishes frozen in shallow lakes by the severe winters of Canada have been carted like bricks considerable distances, and after many days restored to life in their natural habitat; * and Dr. Carpenter is responsible for the statement that there is nothing in the constitution of man to preclude the possibility of similar treatment. The idea has, of course, been seized on by the litterateurs; not long ago the humourist of the New York Times made excellent fun of the presumed possibility. M. Edmond About has devoted a whole novel to the situation, in which a frozen officer is revived to life after an enforced hibernation for many years, and only lately a gentleman in a northern colony gave a vivid account of the freezing and resurrection of a young sheep. For all that, it is by no means impossible that animals, with the organisation of fishes, may not be frozen before death and revived, after weeks of refrigeration, here to us in their habit as they lived, and find a later and more natural sepulchre in appreciative stomachs.

CONSULTATION WITH HOMŒOPATHS.

Dr. Quain's consent to consult with Dr. Kidd in the case of the late Lord Beaconsfield has provoked, as might have been expected, general condemnation in the profession. He has, to some extent, the excuse of the approval of some "leading" medical men, whose names, however, do not transpire, and whom we suspect to have been more moved by an enthusiastic loyalty to Her Majesty's wishes in the dangerous illness of a specially favourite minister than by regard to the ordinary situations conditioning medical practice. In the correspondence which ensued there is not a single defender of Quain, the controversialists being supplied from the ranks of the homœopathists, none of whom, however, endeavour to explain why, when death is imminent, the patient and his friends so often fall back for

* The inhabitants of Northern Scotland tell of parallel experiences regarding eels.
succour on the orthodox school of medicine. We can point to similar experiences among ourselves. The life of more than one public man, whom the colony could ill afford to lose, has been at the mercy of the Hahnemannists during serious illness, and literally at the last moment the patient or his friends have sought the advice of a practitioner whose tenets, they have expressed their total disbelief in. The Victorian homœopath, like his congeners, is wise in his generation, and finding, to our credit be it said, no countenance from us, having exhausted his *inter se* consultations, professes his willingness to surrender, of course at the lethal hour, his attendance on the case.

It is an inexplicable, and we may add, disreputable fact that members of a school which takes as its basis Hahnemann's doctrine of dynamisation, yea to the tre-cillionth power, and adopts the theory of similars, should secretly live, move, and have its being, when in serious issues, by an admitted behaviour quite contrary. They point to Ringer and Murrell as having adopted in their therapeutics the "*Similia similibus curantur*" Shibboleth, but Ringer's one-drop doses of liquor arsenicalis in the vomiting of alcoholic gastritis (which careful practitioners know will exhaust itself by abstinence), is by no means a proven cure; and if it were, the difference in so potent a drug between one drop and a millionth cannot be argued away.

If one fact more than another is observable in recent therapeutics it is that in many cases for a cure nothing but the full tolerated dose of a medicine is efficient. Such is the basis of Hyde Salter's treatment of asthma, of Garrod's colchicum treatment for gout, of Liebermeister's quinia saturation in typhoid, of Maclagan's salicylic remedy in rheumatism. In the latter instance in particular it is more than useless to adopt any conventional method of exhibition. The drug must be pushed in full doses hourly till the disease is affected, and then by a *diminuendo* process less and less onwards to convalescence. No rational person would argue that the first effects of alcohol or chloroform prove them merely excitants, and we insist that the future
of therapeutics lies in pushing remedies to individual saturation, since everybody has his personal therapeutic equation, rather than in the opposite direction. A drop, much less a dynamised quantity of brandy, will not affect a colic, while an ounce will often act with magical completeness.

An interesting result of this controversy has been that when the *Lancet* pointed out that Dr. Kidd, hitherto the protagonist of the homœopaths, had his name still in the Homœopathic Register and on the committee of the Homœopathic Hospital, that astute gentleman wrote to intimate that he had directed his name to be withdrawn, and intimated his wish to join with those who were honest seekers for truth, and not mere titillators to the fashionable belief that dynamised sugar pills and drops of tasteless water are potent in disease, and by no means procurers to that insatiable desire among women of both sexes to peddle with drugs and air themselves with all the amateur's confidence of power over life and death.

**Review.**


Asepticism has gone far towards removing one of the principal dangers attending the deligation of an artery for the cure of aneurism, and should further experiments justify the results already obtained from the use of the flat ligature, we may hope at no far distant period to eliminate from our calculations the hitherto dreaded accident of secondary haemorrhage.

The first chapter of Dr. Barwell's little work, though partly introductory to the subject of aneurism in general, is mainly devoted to the description of the flat or ribbon ligature, its mode of preparation, method of employment, and to the enumeration of the special advantages which it possesses over all other forms of ligature. The subsequent chapters treat of aneurism in the different regions of the body; the sixth and last, dealing with aneurisms of the arch of the aorta, being of special importance.
Before John Hunter's time operations intended for the cure of aneurism were mostly fatal. He tied the vessel at a considerable distance from the aneurismal tumour and in sound tissue, a great improvement on the system previously in vogue. But to the work of Dr. T. D. Jones on hemorrhage and the use of the ligature, we are indebted for the views which mainly guide our present practice. He taught that the ligature should be used in such a manner as to “cut through the internal and middle coats of the artery, and bring the wounded surfaces into perfect apposition.”

But lately, and especially since the introduction of the cat-gut ligature, it became apparent that these views must be somewhat modified. Aneurisms are curable by external pressure, producing coagulation of blood within the vessel and sac, and without inducing adhesive inflammation. Why may not a like result be obtained by tying the vessel sufficiently tight to arrest the flow of blood within it, but not tight enough to divide its coats? Such a procedure, impossible with the old hempen ligature, difficult with wire, is feasible with catgut. But the tendency of the knots to slip and the difficulty of gauging the exact amount of pressure required to occlude the artery, and yet not divide its coats, induced Mr. Barwell to look about for some other tying material which would be more suitable to the end he had in view.

“The only form of ligature,” he says, “as far as my experiments go, which can be relied upon not to divide arterial coats, that is to say which can be tied firmly round an artery and yet will leave it uninjured and hemorrhage proof, is a flat or tape-like band. Such a ligature must not dissolve too quickly, must not excite inflammation, and must bear a secure and reliable knot.”

After trying a variety of substances it occurred to him to use arterial tissue itself, and experiments showed him that a ribbon ligature cut from the aorta of an ox fulfilled all the requirements. The fresh aorta after being thoroughly cleansed is soaked for some hours in a 3 per cent. solution of carbolic acid. The outer or inter-cellular coat is then scraped off, and a narrow ribbon of the remaining two coats is cut spirally with a scissors. The redundant elasticity which impedes the secure tying of a knot is removed by suspending a weight of from two to four pounds from the ligature, and it is preserved until required for use in antiseptic gauze.

Up to the time of the publication of Mr. Barwell’s book in 1880 the flat ligature had been used in seven cases, in which some of
the largest arteries in the body were tied, viz., two carotids, two subclavians, two femorals, and one external iliac, and the result in every case was a success.

It is not intended that the use of the ribbon ligature should supersede the other recognised modes of treatment, such as diet, rest, pressure, &c., but that when these have been tried and have failed, it is safer than any other method. But he goes farther, and says that many cases, which hitherto would have been subjected to pressure, can more quickly, with greater comfort to the patient, and with a better prospect of success, be treated with the flat ligature.

The sixth and seventh chapters are of special interest, dealing as they do with aneurisms of the aortic arch.

In 1869, Dr. Cockle read a paper at the Medical Society of London, detailing cases of aneurism of the arch which had been cured by occlusion of the left common carotid artery under a mistaken diagnosis. Following out this idea, several cases have been so treated by Messrs. Holmes, Heath, and Barwell "with incontestable benefit." It is not to be supposed that every case of aneurism of the arch can be surgically treated. On the contrary, Mr. Barwell states that only the sacculated form and slight and limited dilatations are amenable to this treatment, and an accurate diagnosis of the exact seat of the disease is in every case necessary.

Mr. Barwell's work makes a step in advance in a most important branch of surgery, and we strongly recommend it to be carefully studied by those amongst our readers who are interested in the diagnosis and treatment of aneurism.

J. P. R.

Extracts from the Medical Journals.

In the June Lancets, Dr. Handfield Jones concludes his clinique on cases of anomalous rheumatic fever, in the treatment of which, salicylate and quinine were found useless, and cold bathing only temporarily antipyretic, simple sponging being quite as effective as the bath.

Dr. Mouat, formerly Professor of Medicine at the Medical College, Calcutta, contributes what promises to be an exhaustive paper on Hospitals and their management. He argues very properly against the excessive number of beds, so common, and
asserts that no hospital should exceed a maximum of three hundred.

Dr. George Harley contributes a series of articles on etiology, and the clinical bearings of the germ theory of disease, accompanied by valuable illustrations. From his experiments on vegetable organisms, he concludes that certain kinds of these germs are innocuous, even when introduced into the circulation; that certain kinds of spores cannot develop in healthy blood; that a fungus may become toxic by changing the soil of growth; that the action of these fungi in the blood is mainly chemical. His classification of the germs which produce human disease is valuable from its simplicity. He makes seven divisions, arranged in the inverse order of their potency:—1. Brownian granules, which are normally in the blood and other fluids, and abnormally in milk, urine, and decomposing animal fluids. 2. Vibriones, found in decomposing animal fluids, and in the contagious liquids of gonorrhoea, small-pox, &c. 3. Micrococci, pellucid spherical bodies found in small-pox pus, in the blood of putrid fevers, and in diphtheria. 4. Bacteria, sausage-shaped germs found in living fluids, under pathological conditions, and in all decomposing animal matters, such as the blood in fowl-cholera. 5. Spirilli, found in woolsorter's disease. 6. Bacilli, and lastly, germ-spawn, which is a fine granular matter.

A good case is related from Newark of a fractured skull in a child, where effusion of cerebro-spinal fluid took place under the scalp, and in which aspiration was followed by recovery.

Dr. Galton's case of Caesarian section, though fatal, is instructive.

There is nothing of unusual interest in Dr. Ogilvie Will's clinical lectures on the catheter treatment of perineal fistulae, for which he advises, in opposition to Sir Henry Thompson and others, the tying-in of the catheter.

Dr. Theodore Williams deals with the pathology and treatment of diarrhoea in phthisis. The temperature in these cases is fitful, and it is well to remember in treatment the necessity for the use of alkalies, and especially of phosphates of potash, the component parts of which are noticeably absent from the stools. We are surprised to notice that Dr. Williams recommends veal tea in this complaint—even beef tea is hardly permissible.

Some good instances are furnished of the success of the treat-
ment of compound fractures and wounds of joints by the glycerin acid carbolic of the British Pharmacopoeia.

Dr. Alexander's papers illustrate some rare forms of disease accompanied by lesions of trophic nerves, or trophic centres, and illustrative of trophic changes. The cases adduced comprise an irregular symmetrical pigmentation of the body, accompanied by anaesthesia of the pigmented patches, an elephantiasis, a sloughing of the face from a cortical lesion, and an instance of troublesome syphilitic ulceration of the face which rapidly healed on the removal of some necrosed bone from the calvaria.

Dr. Allan (Glasgow Fever Hospital) urges the employment of enemata instead of purgatives in the constipation of typhoid.

Dr. Playfair completes his account of the great success in his hands of the Weir-Mitchell massage, or dry shampoo treatment, in cases of nerve prostration and hysteria connected with uterine disease. By this plan, women bed-ridden for years and slaves to chloral, morphia, or alcohol are restored to health and strength.

A case of poisoning by belladonna, in which 3 ii 3 ii of the liniment was swallowed, is reported as treated with rapid success by four hypodermic injections of pilocarpin (gr. 1⁄4 every fifteen minutes).

From the Hospitals, Mr. Shanton, of the Staffordshire Infirmary, reports three cases of excision of the tongue, with remarks on the various modes of removal. He is strongly in favour of removal through the mouth, which may be enlarged by the knife, and he is against the more elaborate modern methods.

At King's College, Mr. John Wood removed a scapula for sarcoma; and Mr. H. Smith's case of excision of the upper end of the femur illustrates the necessity for removing the trochanter. A small piece of dead bone, evidently the remains of the head of the femur, was found embedded in the acetabulum. A couple of cases of removal of the thyroid body in goitre are reported from Geneva.

From Westminster we have the particulars of a successful abdominal section for an intestinal obstruction, with advanced peritonitis.

London Hospital contributes an excellent recovery under Listerism from a lacerated wound of the knee-joint.

Mr. Allan's four cases of spinal caries, from Wandsworth Infirmary, illustrate the obscurity often attendant on that complaint, inasmuch as in each the suppuration did not present externally.
Among the doings of the Societies, we find at the Clinical Dr. MacCormac's paper on ununited fracture of the olecranon treated under Listerism by suture of the bone. Lawson's paper advocating excision of the breast in intractable eczema of the nipple. A case of stretching of facial nerve for neuralgia. And the report of an interesting discussion on a case in which a deep blue pigment exuded on the skin (chromoidrosis) of the circumorbital region. The condition was much aggravated by constipation, which suggested the view that the pigment was of the nature of indican, as that occurs in excess in the urine when there is costiveness. The debaters were in doubt whether the pigment was secreted by the sweat glands or the sebaceous. At the Obstetrical the nature of phlegmasia dolens was discussed, and there was a general agreement that venous thrombosis is not a necessary condition of that complaint, but that lymphatic obstruction is. Dr. Galabin related a remarkable instance of extra-uterine foetation, co-existing with intra-uterine foetation, in which abdominal section was performed.

At the Medico-Chirurgical Society, a long discussion was produced by Mr. Croft's paper, advocating the treatment of simple fractures and dislocations of the bones of the leg, by the immediate application of plaster of Paris splints. The Bavarian splint bandage was highly spoken of, it consists of two layers of flannel, between which the plaster is spread. A case of vascular tumour of the face, appeared to exercise the ingenuity of those present in suggesting methods of cure.

Among the new books favourably noticed, we find The Factors of the Unsound Mind, by Dr. Guy. Billing's New York monthly Index Medicus and Hammond's Neurological Contributions.

In the leading articles the subject of nursing is vigorously dealt with. In the annotations attention is drawn to a case of varix of the oesophagus, from which fatal haemorrhage occurred. The value of blisters in anaesthesia is noted. The death of Professor Skoda, at Vienna, suggests an interesting notice. Some benefit is reported from intra-peritoneal transfusion, done antiseptically.

In the correspondence will be found some excellent letters on homoeopathy, an account of a threatened death from chloroform averted by placing a cloth steeped in hot water over the cardiac region.
The death of Rolleston, Linacre Professor of Physiology at Oxford, occasions a long biographical notice.

A Mr. Smith asserts that the size of the English head is steadily decreasing, and has originated a not un instructive discussion.

THE BRITISH MEDICAL JOURNALS.

Recent Progress in the Pathology and Treatment of Cerebral Paralysis.—Dr. Althaus, in a lecture on the above subject, brings before us the results of some recent investigations on the nature and symptoms of paralysis arising from brain-disease. Before plunging into the intricacies of pathology, he dwells on certain anatomical features of the motor zone of the nervous centres, and deprecates the absence, in the hand-books on Anatomy, of that kind of knowledge which has been gained, not so much “by systematic slicings of brains and cords of healthy adults” as by the “infinitely finer and more instructive dissections made for us by disease,” a kind of vivisection which he naïvely remarks “cannot be prohibited by Acts of Parliament.” What is solid in the edifice of localisation of power in the brain and spinal cord, has been contributed by clinical observation and pathological anatomy, while, in those points, chiefly studied “experimentally,” there is still the greatest discrepancy amongst the best observers, experimental pathology being singularly unproductive in the special department of brain disease. Thus glycosuria, which is experimentally brought about, is not the diabetes which we observe clinically, but only a passing physiological storm, certain to disappear in a short time. The experimental pysiologist may divide the posterior columns of the spinal cord, but he cannot induce, in those parts, the peculiar irritation and gradual wasting of nerve fibres found in sclerosis. Dr. Althaus proceeds to review the advances made in the study of the evolution of the nervous centres in the foetus, and more especially the researches made by Dr. Flechsig. By studying the gradual formation of the myeline sheaths of central nerve fibres, Flechsig was able to recognise peculiarities of organisation in the central nerve fibres. Certain fibres and strands of fibres which in the adult are so welded together as to appear identical, may during embryonic life be distinguished from each other, some of them being still naked axis-cylinders, while others are covered with a sheath of myeline. The specimens on which Flechsig founds his conclusions have been prepared partly with perosmic acid, which gives a black coloration
to the fully developed fibres, but leaves those without a sheath of myeline quite clear, and partly by a new means of impregnating the nervous centres with gold. The great automatic centre of motor power and muscular nutrition and tonicity resides in the spinal cord, the gigantic ganglion-cells of the anterior horns being called "motor" or "kinesodic" cells. These cells send the force which is constantly originated in them to the motor nerves and muscles by means of the so-called "Deiters's elongation or axis-cylinder." The destruction of these giant-cells in infantile paralysis causes loss of muscular power, tone, and nutrition; while irritation of them, through secondary sclerosis in adjoining parts after attacks of apoplexy, causes the late rigidity so often the consequence of cerebral hemorrhage. While therefore these giant-cells of the anterior horns furnish an instrument of motor power, the volitional impulses of motion originate in the hemispheres of the brain, and are located in the grey convolution bordering the fissure of Rolands. A third centre of motor power is constituted by the central ganglia on the floor of the lateral ventricles, more especially in the corpora striata. Dr. Flechsig has paid particular attention to the manner in which pyramidal crossing takes place. He describes three types of decussation—(1.) Total crossing of both sides. (2.) Total crossing of one pyramid and semi-decussion of the other. (3.) Semi-decussion of both sides, of which there are two varieties—(a.) Less than 50 per cent.; (b.) more than 50 per cent. of the fibres remain uncrossed, the uncrossed fibres being called direct pyramidal strands, or Türck's columns. These three varieties show that Brown-Sequard's cases of direct hemiplegia are in accordance with the leading facts of cerebral localisation. The peculiarity of diseases of the spinal cord is that symmetrical and homologous anatomical and histological parts are affected, whilst the neighbouring portions escape. In the brain the reverse is the case, disease progressing without regard to structure, but following simply the distribution of blood-vessels. A "neutral zone" exists in the pons varolii and medulla oblongata, when disease will sometimes take the cerebral and sometimes the spinal type, e.g., labio-glosso laryngeal paralysis on the one hand, and haemorrhage into the pons varolii and medulla oblongata on the other.

Observations on Recent Improvements in the Mode of Removing Uterine Tumours.—This is an extremely valuable contribution by
Mr. Spencer Wells, illustrated by several interesting cases of interstitial uterine tumours removed by him through the abdominal walls, and in some of which cases large portions of the uterus were also taken away. Mr. Spencer Wells takes a very encouraging view of the surgical treatment of these cases. In addition to "the complete use of antiseptic precautions," he insists on the divided edges of the peritoneum being brought together, either by "many sutures," or by "an uninterrupted suture along the whole extent of the gap." He considers that by the use of the improved pressure forceps the arrest of haemorrhage will be effected much more easily and completely than before.

Clinical Lecture on a Case of Cesarian Hystero-Oophorectomy, by Alex. Russell Simpson, M.D., F.R.S.E.—This is a case in which Porro's operation, or Cesarian section supplemented by utero-ovarian amputation, was attempted as a dernier ressort in a woman who had on several occasions been delivered by embryotomy, and who wished at any expense to give birth to a living child. In spite of every antiseptic precaution, however, it was unsuccessful. Dr. Simpson gives elaborate statistics of the operation, as performed on the Continent and in America.

Faure's Secondary or Storage Battery.—This is a recent invention, which enables one to carry stores of powerful electricity "in a jar no bigger than an ordinary meat tin." Supplies of these cumulative jars can be charged by any kind of battery to which they are attached.

Swan's Light.—A novel method of examining parts of the body or tumours by a transmitted electric light. Useful in hydroceles.

Un-united Fracture of the Patella.—Two cases are given by Mr. Joseph Lister, in which he obtained successful results by suturing the fragments with silver wire. Formerly the surgeon, in attempting this operation, had to contemplate the probability of a long-continued suppurative process, but now, "by making use of the antiseptic dressings, no such fears need be entertained."

Mr. M'Cormac read the notes of a case before the Clinical Society of London of ununited fracture of the Olecranon process, in which bony union was obtained by sutures of the bones. Mr. Lister has of late made extensive use of eucalyptol in place of carbolic acid. The eucalyptus oil is used by him undiluted as a dressing. It is also made into an ointment, of which the following is the formation:—Vaseline, \(2\frac{2}{3}\) parts; parrafin wax, \(1\frac{1}{3}\) parts; eucalyptus oil, 1 part.
Eucalyptus and Iodoform Emulsion.—Eucalyptus oil and powdered gum acacia, of each 96 grains; iodoform 8 grains, water to 2 fluid ounces.

W. B. W.

THE LONDON MEDICAL RECORDS.
MAY AND JUNE.

Dr. Péter recommends the method of investigating heart disease by examination of the local sensibility of the pre-cardial and pre-aortic regions. He believes that this method will, in course of time, be as much used as auscultation and percussion. He found that many morbid states of the heart had painful spots corresponding to them, the tobacco heart having a tender spot on pressure in the third left intercostal space near the sternum. As this spot is situated over the ganglion of Remak, he thinks that this ganglion is affected through the impregnation of tobacco.

M. Charcot, Dr. B. Ball, and others have shown static electricity in some forms of hysteria, and other nervous diseases, to be a therapeutic agent of great value.

Dr. H. C. March, on some New Uses of Some Old Remedies. An obstinate case of sciatica yielded to copaiba. Half minim doses of liquor hydrargyri bichloridi, every half-hour, acted like a charm in many cases of dysentery. Lime in after gout is often very useful.

Argyrism following repeated applications of argentii nitratus to the pharynx has been observed in three cases.

Dr. W. C. Ayres, in studying the photo-chemistry of the retina, has established the impracticability of detecting a murderer by means of an optogramme. His attempt to produce a picture of Professor Helmholtz on the retina of an animal resulted in an image of Helmholtz’s shirt collar and the end of his nose.

At the International Otological Congress, at Milan, in September last, after the discussion on Professor Moos’s paper, on the frequency of diseases of the ear (generally middle ear catarrh) in railway employees, a resolution was passed drawing the attention of the governments of different countries to the subject. Prof. Moos recommends the periodic examination of the hearing of engineers and firemen at least once in two years, so as to avoid all possible danger to the travelling public from this source.

Dr. Battey, of Georgia, amputated the thigh of a young man suffering from advanced phthisis pulmonalis, complicated with scrofulous disease of the knee-joint. He rapidly grew fat, and led
an active out-door life for three years, when he succumbed to pulmonary hemorrhage. Cases like this may add something to the pathology of phthisis.

Dr. Zander, of Eschweiler, propounds a new theory of chlorosis, the absorption of iron being deficient owing to the want of hydro-chloric acid in the gastric juice. He has obtained the best results from the administration of this acid with the food.

A sudden death from syncope after thoracentesis occurred in the practice M. Tennesson. Probably too much fluid was withdrawn during the operation.

Dr. Aufrecht, of Magdeburg, announces that he has discovered a micrococcus peculiar to syphilitic condylomata.

The experience of M. Mauriac shows that syphilis cannot be prevented by complete excision of the initial lesion.

Herr G. Finne relates a case in which sexual connection with a tuberculous individual is suggested as having been the cause of tuberculosis of the bladder and kidneys in a female.

Dr. P. O'Connell, from the consideration of all published tables, states that the duration of normal human utero-gestation is 275 days.

Dr. Webster, in the New York Medical Record, records 20 cases in which the abuse of alcohol or tobacco, or both, caused amblyopia.

A new splint for Colles' fracture, invented by a Dr. Carr, is described, the principal advantage of which is that it allows the patient to use his fingers and thumb during the treatment, thus preventing the stiffness which frequently remains after this fracture.

Clinical & Therapeutic Memoranda.

LONG RETENTION OF PLACENTA.

A primipara was delivered of a child one evening recently at 8 o'clock. I was sent for the following day, reaching the house at 1 o'clock, when I immediately removed the placenta, just 17 hours after the birth of the child. There was no hemorrhage, no pains, the placenta being loose in the uterus. I have previously removed placenta after being detained 11 hours, 8 hours, 6 hours, &c.

Shepparton.

J. P. FITZGERALD.
Turpentine, the odour of which can be disguised by mixing with it equal parts of the essential oil of lemons, is now largely used in psoriasis.—Lancet, May.

Tannate of quinine in doses of a grain and a half for each year of the child's age is reported from Germany as being almost a specific for whooping cough. It is tasteless and given twice a day.

Bromide of ammonium has also German approval for whooping cough. It is given every two hours in one grain doses for young children, but should not be given when there is chronic bronchial catarrh.

Tinct. iodi in half minim doses every hour, if given early, is said to be a specific in simple croupous pneumonia.

Ext. bellad. gr. ½ every hour will often remove an intestinal obstruction.

M. Fereol still reports his success in treating neuralgia of the fifth nerve with ammoniacal sulphate of copper.

In herpes, a drachm of iodoform dissolved in half an ounce of oil of eucalyptus is recommended by Dr. Howard, Illinois, who also uses one part of iodoform to five of sugar of milk as a local application in granular lids.

Iodoform may be dusted over tuberculous bones and joints.

Glycerine has been used with success in trichinosis, a treatment based on the fact that glycerine applied to living trichinae shrivels up and kills them.

Resorcin (three per cent. solution) acts in diseases of the stomach as a haemostatic and preventer of fermentation.

Scruple doses of copaiba every four hours will often cure sciatica.

Liq. hyd. bichlor. m.ss. every half hour will often cure dysentery.

Beef tea is a good vehicle for salicylic acid.

A soft paste of calcined magnesia and water will allay pain from vitriol burn and prevent scarring.

Inhalations of chamomile water medicated with carbolic acid, balsam of Peru, and creasote glycerine are useful for laryngeal tuberculosis.

For belladonna poisoning, give tincture of opium and use hypodermic injections of pilocarpin (gr. ½) every quarter of an hour.
Half an ounce of infusion of tansy is reported as having caused death.

Prof. Binz has proved that chlorine, iodine and bromine when inhaled paralyse the nerve centres, and recommends the use of disinfectants which give off oxygen or ozone rather than chlorine as chloride of lime does.

Pilocarpin, hypodermically, has been used with success in fetid perspiration of the feet.

A wet compress of solution of sulphate of atropine (1 part to 1000) relieves the pain of cancer without the danger of absorption.

Oil of ergot (obtained by exhaustion with benzine and evaporation) is in use in America for eczema.

Tincture of musk in the proportion of one drop to the ounce will mask the odour of iodoform.

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**Local Subjects.**

The thirteenth ordinary meeting of the Students' Society was held on July 21st, at the Melbourne Hospital. Dr. Allen was in the chair, and 15 students were present. Mr. Bage read "Notes of a Case of Hydatid," and after an interesting discussion, Mr. Syme read "Notes of a Case of Myelitis." The chairman made some remarks, and the meeting terminated.

The fourteenth ordinary meeting was held on August 4th at the Medical School; 22 members were present, and Dr. Kirkland was in the chair. Mr. Barrett read a paper on the "Comparative Anatomy and Elementary Physiology of the Circulatory System," with demonstrations by Mr. Palmer and Mr. J. B. Kirkland. After this the meeting terminated.

At a meeting of the Executive held on the 9th inst., Dr. Alexander Shields was appointed Chief Medical Officer.

Dr. H. L. Miller has been appointed Medical Superintendent of the Melbourne Hospital.

At the last meeting of the Medical Board of Victoria, the names of the following gentlemen, with the qualifications attached, were inserted in the Medical Register:—James Charles M'Kee, L.R.C.P. et L.R.C.S. Edin. 1881; Edwin Godson, M.R.C.S. Eng. 1880.

At the Annual Meeting of the Victorian Branch of the British Medical Association, held on the 22nd ult., the following gentlemen were elected office-bearers for the ensuing year:—President, Dr. Neilh; Vice-President, Dr. Jamieson; Treasurer, Dr. Cutts; Hon. Secretary, Dr. Henry; Ordinary Members of Council, Dr. Graham, Mr. Gillbee, Dr. Morrison, Dr. Adam, Dr. Shields, and Dr. Fyffe; Auditors, Dr. Haig and Mr. W. Barker.

Miss H. Elphinstone Dick and Miss A. C. Moon are giving a series of lessons in Elementary Physiology at the Ladies' Gymnasium, Collins Street West. The course, which is intended for ladies only, is divided into the
following sections:—General Structure of the Body; Respiration; Circulation of the Blood; Alimentation; The Brain and the Nervous System; The Skin; The Organs of the Senses, and the Application of Physiological Knowledge to the Preservation of Health. Such information as the above programme indicates cannot fail to be of immense value to young ladies, and the intelligence hitherto displayed by Miss Dick and Miss Moon in the conduct of their gymnasium, is a good earnest of their capabilities to undertake such a project. We wish them every success.

BIRTHS.


LEFEVRE.—On the 12th inst., at 93 Collins-street East, Mrs. Le Fevre of a daughter.

LEGGATT.—On the 13th inst., at Sunbury, the wife of A. J. Leggatt of a son.

PHILLIPS.—On the 30th ult., at Stanley-street, West Melbourne, the wife of Walter Phillips, M.B., of a son.

ROBERTSON.—On the 13th inst., at Claremont, Alma-street West, St. Kilda, the wife of Robert Robertson, M.R.C.S., Eng., of a daughter.

MARRIAGES.

O'BRIEN—FORDS.—On the 19th ult., at the Roman Catholic Church, Yackandandah by the Rev. M. O'Conner, assisted by the Very Rev. Dean Tierney, John A. O'Brien, M.B., C.M., Beechworth, to Louisa Mary Helen, only daughter of the late Dr. James Forde, Yackandandah.

STEWART—HENRY.—On the 2nd inst., at the residence of the bride's parents, Northampton-house, Acland-street, St. Kilda, Dr. Douglas Edward Stewart, son of the late Dr. W. R. Stewart, of Tasmania, to Herminia Isabella, daughter of David Henry, of this city.

DEATHS.

GIBSON.—On the 13th inst., after a short illness, at his residence, Flemington-hill, James Gibson, surgeon, aged 57 years.

HALL.—On the 30th ult., at his residence, 58 Campbell-street, Hobart, Tasmania, Dr. Edward Swarbreck Hall, health officer for Hobart, in his 77th year.

NOTICES TO CORRESPONDENTS.

Communications have been received from Dr. J. Davies Thomas, Dr. Jakins, Dr. J. P. Fitzgerald, Dr. Snowball, Dr. Walsh, Dr. P. B. Bennie, Dr. Balls-Headley, Miss H. Elphinstone Dick, &c.

PUBLICATIONS RECEIVED.

British Medical Journal for June 11, 18, 25, and July 2; Medical Press and Circular for June 8, 15, 22, 29; Students' Journal for June 4, 18, and July 2; Glasgow Medical Journal for June; New York Medical Journal for June; Independent Practitioner for May and June; Pacific Medical and Surgical Journal for June; Proceedings of the Medical Society of the County of Kings for June; Annals of Anatomy and Surgery for June; American Journal of Insanity for April; St. Louis Conrier of Medicine for June; Canada Medical and Surgical Journal for June; Medical Herald (Louisville Ky.) for June; Medical Record (N.Y.) for May 28, June 4, 11, 18, 25; Board of Health Bulletin for May 21, 28, June 4, 11, 18; Chemist and Druggist Supplement for June; Victorian Government Gazette, and Proceedings of Parliament (to date); Clinical Illustrations of Faces, by L. Duncan Bulkley, M.D.; Victorian Patents and Patentees, vol. XII.; Notes on Sanitary Points.