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Original Articles.

SEVERE HEAD INJURIES—RECOVERY.

By P. McP. Reid, M.B., C.M. Edin., M.R.C.S. Eng.,
L.R.C.P. Lond.

The following case seems worthy of record, as an instance of almost uninterrupted recovery after undoubted fracture of the base of the skull, and further as presenting some interesting points in diagnosis:

E. S., æt. 25, a strong healthy woman, was being driven at a smart pace in a dog-cart, when the horse suddenly stumbled. She is stated to have been pitched out "as though diving from a spring-board," landing on the top of her head on the macadamised road. She was carried in an unconscious condition to a house about a hundred yards away. I saw her twenty minutes after the accident. She then appeared to be at the point of death from shock, but the pulse gradually improved under stimulating treatment by ether injections, hot water bottles, &c.

In addition to the ordinary phenomena accompanying concussion, the chief points noted were:—Blood stains on both nostrils, but no present discharge. A linear depression could be seen and felt, extending from upper and outer part of left frontal eminence to centre of left upper orbital margin. There was ecchymosis of left upper eyelid, with protrusion of the eyeball, and subconjunctival haemorrhage. There was a watery discharge, blood-stained and frothy, from left ear. A bubbling sound was heard as coming from the left ear. On applying stethoscope to the external meatus, air was found to be puffed out freely with each
expiration; she was breathing with the mouth open at the same time. Every few minutes dark grumous blood was vomited. On cutting the hair, there was seen a livid contusion, three-quarters of an inch wide, and five inches long, extending obliquely across the vertex from left parietal eminence to right frontal region; this evidently marked the line of impact.

As regards the progress of the case:—She was in a comatose condition for forty-eight hours, and then gradually regained the use of her faculties. The vomiting of blood continued at lengthening intervals for twenty-four hours after the accident. A copious clear discharge (found to contain sodium chloride in quantity) flowed from the ear—with one intermission—for nine days, then lessened, and ceased on the tenth day. The intermission occurred on the fourth day, when for twelve hours the discharge was very slight; concurrently with this diminution, the temperature rose from normal to 103°; the flow was then resumed, and the temperature quickly fell. With this exception, the temperature was practically normal throughout. There was no paralysis observed. After the first week she progressed rapidly, and without any alarming symptoms. She was out of bed in five weeks, the only apparent permanent damage being total deafness on left side, even to bone conducted sounds.

The treatment adopted briefly was:—Perfect rest and quiet. Ice to head constantly. Bowels kept well open by glycerine suppositories, calomel, and mag. sulph. Iodoform blown into ear. Catheterisation first three days. The diet for first five days was restricted to iced soda and milk.

Nature of the injuries:—There was evidently a fissured fracture through the left frontal eminence, superciliary ridge, and orbital plate. The fracture in the frontal region gaped to a degree quite unusual, and was very evident. That the orbital plate was involved, was shown by ecchymosis of the eyelid, sub-conjunctival haemorrhage, and protrusion of the eyeball. In addition, there must have been a fracture of the petrous bone, extending probably from its cerebral to its inferior aspect. This must have involved the tympanum and membrana tympani, and must have been continuous above with a rent through the dura mater and arachnoid. There is also a strong suggestion of its being connected below with a tear in the mucous membrane of the pharynx. That the sub-arachnoid space was opened, and the tympanic membrane torn, was shown by the long continued copious discharge.
of fluid from the ear. That the pharyngeal mucous membrane was torn, seems to be indicated by the perfect freedom with which air passed through the ear during ordinary expiration, the patient breathing through the mouth at the same time. I think one was forced to assume the existence of a larger channel than would be provided by a normal eustachian tube. The auditory nerve seems to have been involved, as perception of sound by bone conduction on that side is gone. The facial apparently escaped serious damage.

As to the significance of the continued vomiting of blood:—In most cases, this points to fracture of the ethmoid, sphenoid, or basilar process of the occipital; but here it seems probable that the blood came from a source not usually indicated in text-books, namely, through a rent in the pharyngeal wall, in connection with a petrosal fracture.

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**Medical Society of Victoria.**

**Ordinary Monthly Meeting.**

**Wednesday February 3rd, 1892.**

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

The President, Professor Allen, occupied the chair, and there was a fair attendance of members.

The minutes of the previous meeting were read and confirmed.

The President stated that he had written, on behalf of the Society, to the Chief Secretary, protesting against the compulsory retirement of the Government Botanist, Sir Ferdinand von Mueller, and had been informed in reply, that it was not intended to cause Sir Ferdinand to retire. The Secretary had also received a letter from Sir Ferdinand, thanking the President, the Committee, and the members of the Society for the action that had been taken.

The President announced that the Roll of Members would be revised at the next meeting of the Committee.

W. R. Boyd, M.D., &c., of Hoddle Street, Richmond, proposed by Dr. Adam, seconded by Dr. Moore, was elected a member of the Society.

The nomination of one gentleman for membership was received.
The following paper was then read:

AN ANALYSIS OF CASES OF LEAD PALSY TREATED BY GALVANISM.

By Chester Eardley-Wilmot, M.B., B.S.

Late Assistant Electrician to St. Bartholomew's Hospital.

The appearance of a monograph on Lead Poisoning by Professor Oliver led me to think that a few remarks on the paralyses due to lead, viewed from an electrician's standpoint, might be of interest to you. I have tabulated here the results of the electrical examination of sixty-two cases of paralysis due to lead, and the effect of galvanism on fifty-four of these.

I should like to emphasize first the two distinct forms of paralysis met with, a distinction between them being of great importance as regards prognosis. The first and most common variety is the degenerative form, which commences more often in the extensors of one or both hands, causing the well known wrist drop, where loss of power precedes wasting. I may remark, in passing, that it appears to me that atrophy follows this loss of power more rapidly than in degenerative paralysis due to other causes. The second is the atrophic form, in which the loss of power and wasting come on at the same time, and proceed equally together. This form is found first of all to attack the muscles of the thenar or hypo-thenar eminences, or the interossei.

In the ordinary degenerative form, the order in which the muscles are usually attacked, is as follows:—First the common extensors, then the index extensors, followed by the radial and ulnar extensors, then by the muscles of the thenar and hypo-thenar eminences, the supinator longus then becomes affected, and I think this is involved more often than is usually supposed. In these sixty-two cases it was affected four times. The biceps, triceps, and brachialis anticus always escape; on careful examination, I have never seen any of them affected. The deltoid and supra- and infra-spinatus will often become affected. Occasionally also the legs become affected, in which case the peroneal muscles suffer most. Although the muscles are generally attacked in groups, one or two muscles out of an affected group often escape. In case 15, the extensor ossis metacarpi pollicis escaped. In case 29, the little finger escaped. In case 48, the index and little fingers both escaped.
As regards age, the most common age in which it is met with seems to be between 35 and 45, as shown in the accompanying table.

The greater susceptibility of women to the poison, as emphasized by Professor Oliver, is well shown in the three female cases included in the table. One had only worked for two months in a lead factory, and, six months after leaving it, had been attacked with double wrist drop. The second had had first attack of colic after only ten weeks in a lead factory, and, in sixteen days after the paralysis was first noticed, had her supinators affected, and complete loss of faradic contractility in the whole of the musculo-spiral group of muscles.

According to most authorities (Gowers, Erb, and Bastian), the general reaction found in muscles paralysed owing to lead, is that of degeneration, i.e., a loss or impairment of faradic contractility, with a quantitative increase of galvanic irritability, and a qualitative variation also; the order of contractions obtained while increasing the current from a minimum being altered, and the A.C.C. appearing at the same time, or even before the K.C.C. Now, in my opinion, this reaction of degeneration is far from being common. On glancing at the table, it will be seen that the reaction more commonly met with is an impairment of faradic contractility, with normal galvanic irritability, both quantitative and qualitative. This reaction was met with in 24 per cent. of the cases. The next common reaction is an impairment of both faradic contractility and galvanic irritability, but with no qualitative change. This group comprised 16 per cent. of the cases. In 14.5 per cent. the reactions were completely normal. Thirteen per cent. had a complete loss of faradic contractility with a normal galvanic reaction, this being the later stage of group No. 1. Five cases had lost all reactions whatsoever, a still further development of the last group. In ten cases only was there an increase of galvanic irritability. Twelve cases only showed the qualitative change. In two cases alone, out of the sixty-two, was the double change present which constitutes the reaction of degeneration, being slightly over 3 per cent. of the total cases. And that this was not because many of the cases were seen either before the reaction had had time to develop, or after it had disappeared, can be seen by a glance at the table, as some of the cases with normal, or nearly normal reactions, were seen after the paralysis had lasted two, three, five, and up to eighteen months; and some of
those in which the faradic reaction had gone altogether, and with
a yet normal galvanic reaction, were seen as early as the four-
teenth, sixteenth, and twenty-first day. This, then, shows that
the conductility of the nerves remains fairly normal, the muscles,
as might be expected, showing the result of atrophy and non-use,
and points in a significant manner to a central origin to the
disease.

As regards prognosis, the atrophic form of paralysis is far more
serious, both as to the length of the time before improvement
occurs, and also as regards the probability of complete recovery.
In the degenerative form, the earlier a case is taken in hand, and
the smaller the number of muscles affected, the better the result.
The more nearly normal the reactions are found to be, the better
the prognosis. In the two cases in which the full reaction of
degeneration was present, one showed little improvement after
three months’ treatment, and the other was only slightly better
after six months. In those cases in which the partial reaction of
degeneration was present, the progress was very slow. Other
factors that should cause a guarded prognosis are the presence of
gout, or muscular tremors, and in all attacks after the first.

The treatment is the constant current. When the paralysis is
confined to a special group of muscles, the anode should be placed
on the cervical region of the spine, and the kathode to the para-
lysed muscles. Some authors advocate applying the anode to the
motor point of the nerve affected, and the kathode to the muscles
supplied by it. Looking, however, as I do on the lesion as one of
central spinal origin in the grey anterior columns, I consider it
necessary to place the whole course of the nerve, as well as the
centre governing it, under the influence of the electrical current.
In cases where the paralysis is more general, the bath is the best
means of applying the current, the constant current being of
course used. When applied by means of electrodes, the current
strength should be commenced at three milliamperes, never
exceeding five; and in the bath one hundred milliamperes are
used, eighty of which escape by the water, while twenty pass
through the patient.

In the colic accompanying lead poisoning, faradism to the
abdomen gives good results in relieving it, as well as the con-
stipation. The action of the current is two-fold:—(1) Increasing
the tone of the nerve and its centre, and improving its conductility.
(2) By stimulation of the vaso-motor nerves, it increases the blood supply and nutrition of the muscles, preventing the atrophy, or restoring the muscles to their normal state, if it has already occurred.

Of the fifty-four cases under treatment, three were patients on two separate occasions, making fifty-seven in all. Nineteen were cured absolutely. Four showed no improvement. Thirty-four were reported to be either better or much better on the last occasion I saw them, and as the majority of these were hospital patients, and, as you know, hospital patients have a way of disappearing without reporting themselves when well, though they return readily enough when not, a fair presumption I think is, that at least half of these were cured.

The four cases in which there was no improvement were briefly as follows:

No. 20.—Seen after two months, the deltoid was affected even at this stage, the R.D. was present.

No. 34.—Seen two months after wrist drop had developed. He had had the atrophic form of paralysis three years previous, and had never completely recovered. Had been at his occupation sixteen years, and was still following it. Had had colic off and on for ten years.

No. 36.—Was seen after three months; it was his second attack; had gout and great wasting of muscles, and had complete loss of faradic reaction.

No. 38.—Was seen after he had wrist drop for five years; the supinators were affected; had tremors; R.D. present. Was a lead worker of thirty years' standing, and had not given it up.

Cases of paralysis due to lead, are said to get well without electrical treatment, as a rule, in six to twelve months. In my experience with electrical treatment, the majority get well in three months.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Work</th>
<th>Period of Work</th>
<th>Previous Colic</th>
<th>Duration of Palsy</th>
<th>Muscles Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>43</td>
<td>Solder maker</td>
<td>23 years</td>
<td>None</td>
<td>6 weeks</td>
<td>Extensors of right hand</td>
</tr>
<tr>
<td>2</td>
<td>29</td>
<td>Painter</td>
<td></td>
<td>None</td>
<td>1 month</td>
<td>Extensors of both hands</td>
</tr>
<tr>
<td>3</td>
<td>36</td>
<td>Painter</td>
<td></td>
<td>None</td>
<td>2 months</td>
<td>Left extenders more than right, Right extenders of both hands</td>
</tr>
<tr>
<td>4</td>
<td>30</td>
<td>Plate-glass beveller</td>
<td></td>
<td>3 months ago</td>
<td>1 month</td>
<td>Extensors of both hands</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td>Glass beveller</td>
<td></td>
<td>3 months ago</td>
<td>1 month</td>
<td>Right worse than left</td>
</tr>
<tr>
<td>6</td>
<td>51</td>
<td>Painter</td>
<td>40 years</td>
<td>4 years ago</td>
<td>2 months</td>
<td>(R) Muscles of thenar and hypothenar</td>
</tr>
<tr>
<td>7</td>
<td>26</td>
<td>Blind maker</td>
<td></td>
<td>6 weeks ago</td>
<td>6 months</td>
<td>L. Eminences &amp; interossei both sides</td>
</tr>
<tr>
<td>8</td>
<td>42</td>
<td>Painter</td>
<td></td>
<td>Several times</td>
<td></td>
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</tr>
<tr>
<td>9</td>
<td>28</td>
<td>White lead worker</td>
<td>15 years</td>
<td>None</td>
<td>4 months</td>
<td>(L) Extenders; contraction of flexors</td>
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<td>3 attacks</td>
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<td>11</td>
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<td>6 years</td>
<td>6 years ago</td>
<td>4 months</td>
<td>Both hands equally</td>
</tr>
<tr>
<td>13</td>
<td>27</td>
<td>Plumber</td>
<td></td>
<td>None</td>
<td>5 months</td>
<td>Right side worse than left</td>
</tr>
<tr>
<td>14</td>
<td>P66</td>
<td>Lead factory</td>
<td>9 months, ago</td>
<td>None</td>
<td>1 month</td>
<td>Extensors; except extensors ossea of metacarpic pollicis.</td>
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<tr>
<td>15</td>
<td>38</td>
<td>Glass beveller</td>
<td>2 months</td>
<td>None</td>
<td>6 days</td>
<td>Right side worse than left, Left side</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Thener muscles wasted on right, Right side only</td>
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<tr>
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<td>55</td>
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<td>25 years</td>
<td>None</td>
<td>3 weeks</td>
<td>Extensors of both hands</td>
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<tr>
<td>17</td>
<td>42</td>
<td>Painter</td>
<td></td>
<td>(?)</td>
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<tr>
<td>18</td>
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<td></td>
<td>2 months ago</td>
<td></td>
<td>Left side</td>
</tr>
<tr>
<td>19</td>
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<td></td>
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<tr>
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<td>39</td>
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<td>6 years</td>
<td>8 years ago</td>
<td></td>
<td>Left side</td>
</tr>
<tr>
<td>21</td>
<td>39</td>
<td>Painter</td>
<td></td>
<td>1 year ago</td>
<td>9 months</td>
<td>Extensors of both hands</td>
</tr>
<tr>
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<td>6 weeks back</td>
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<td>Right worse than left, Both hands equally</td>
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<td>Deltoids affected</td>
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<td>2 years ago</td>
<td>2 weeks</td>
<td>Both hands equally</td>
</tr>
<tr>
<td>24</td>
<td>38</td>
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<td>5 years</td>
<td>1 month ago</td>
<td>2 weeks</td>
<td>Both hands equally</td>
</tr>
<tr>
<td>25</td>
<td>43</td>
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<td>Left hand worse than right</td>
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<td>33</td>
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<td>16 years</td>
<td>None</td>
<td>6 months</td>
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<tr>
<td>27</td>
<td>32</td>
<td>Painter</td>
<td>10 years</td>
<td>3 months ago</td>
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<td>Right side worse than left, Both sides equally</td>
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<td>31</td>
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<td>12 years</td>
<td>1 year ago</td>
<td>9 months</td>
<td>Little finger free</td>
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<td>32</td>
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<td></td>
<td>3 years ago</td>
<td></td>
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<td>34</td>
<td>32</td>
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<td>16 years</td>
<td>10 years ago</td>
<td>6 months</td>
<td>Right hand worse than left, Both hands equally</td>
</tr>
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<td>35</td>
<td>34</td>
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<td>6 years</td>
<td>Several times</td>
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</tr>
<tr>
<td>36</td>
<td>52</td>
<td>Painter</td>
<td></td>
<td>6 years ago</td>
<td></td>
<td>Right hand worse than left</td>
</tr>
<tr>
<td>37</td>
<td>57</td>
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<td>6 months ago</td>
<td></td>
<td>Extensors of both hands</td>
</tr>
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<td>Cook</td>
<td></td>
<td>30 years ago</td>
<td></td>
<td>Extensors of both hands</td>
</tr>
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<td>32</td>
<td>Painter</td>
<td></td>
<td>4 years ago</td>
<td></td>
<td>Extensors of both hands</td>
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<tr>
<td>40</td>
<td>32</td>
<td>Painter</td>
<td>2 years ago</td>
<td>2 years ago</td>
<td>5 months</td>
<td>Extensors of both hands</td>
</tr>
<tr>
<td>41</td>
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<td>5 weeks ago</td>
<td>5 weeks ago</td>
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<td>42</td>
<td>30</td>
<td>Painter</td>
<td>18 months ago</td>
<td>3 months ago</td>
<td></td>
<td>Both sides equally</td>
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<tr>
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<td>Painter</td>
<td></td>
<td>3 years ago</td>
<td></td>
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<tr>
<td>44</td>
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<td>None</td>
<td>2 months</td>
<td>Both hands equally</td>
</tr>
<tr>
<td>45</td>
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<td></td>
<td>10 years ago</td>
<td></td>
<td>Left side</td>
</tr>
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<td>57</td>
<td>Painter</td>
<td>14 years</td>
<td>16 months ago</td>
<td></td>
<td>Left side</td>
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<td>42</td>
<td>White lead worker</td>
<td></td>
<td>3 months ago</td>
<td></td>
<td>Left side</td>
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<td>48</td>
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<td>20 years</td>
<td>None</td>
<td>3 weeks</td>
<td>Extensors of both hands</td>
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<td>49</td>
<td>52</td>
<td>Plumber</td>
<td>32 years</td>
<td>16 years ago</td>
<td>6 weeks</td>
<td>Both hands equally</td>
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<tr>
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<td>49</td>
<td>Japanese</td>
<td>6 years</td>
<td>12 months ago</td>
<td></td>
<td>Left worse than right</td>
</tr>
<tr>
<td>51</td>
<td>56</td>
<td>Type founder</td>
<td>45 years</td>
<td>10 days</td>
<td></td>
<td>Left side</td>
</tr>
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<td>52</td>
<td>62</td>
<td>Painter</td>
<td>32 years</td>
<td>3 months ago</td>
<td></td>
<td>Thener &amp; hypothenar muscles wasted</td>
</tr>
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<td>53</td>
<td>50</td>
<td>Painter</td>
<td>16 years</td>
<td>2 weeks ago</td>
<td></td>
<td>Right hand only</td>
</tr>
<tr>
<td>54</td>
<td>38</td>
<td>Lead worker</td>
<td>6 years</td>
<td>Twice</td>
<td>1 month</td>
<td>Right hand only</td>
</tr>
<tr>
<td>55</td>
<td>63</td>
<td>Color grinder</td>
<td>30 years</td>
<td>Never</td>
<td>1 month</td>
<td>Right hand only</td>
</tr>
<tr>
<td>56</td>
<td>26</td>
<td>Glass beveller</td>
<td>6 years</td>
<td>1 month</td>
<td></td>
<td>Left worse than right</td>
</tr>
<tr>
<td>57</td>
<td>36</td>
<td>Lead worker</td>
<td>9 years</td>
<td>7 months</td>
<td>3 months</td>
<td>Only right hand affected</td>
</tr>
<tr>
<td>58</td>
<td>54</td>
<td>Lead worker</td>
<td>30 years</td>
<td>Never</td>
<td>5 years</td>
<td>(Extensors of both hands; supinators affected.)</td>
</tr>
<tr>
<td>59</td>
<td>36</td>
<td>Lead worker</td>
<td>10 years</td>
<td>2 months</td>
<td></td>
<td>Extensors of both hands</td>
</tr>
<tr>
<td>60</td>
<td>51</td>
<td>Lead worker</td>
<td>12 years</td>
<td>3 months</td>
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<td>Extenders of both hands</td>
</tr>
<tr>
<td>61</td>
<td>29</td>
<td>Metal refiner</td>
<td>9 years</td>
<td>6 years</td>
<td></td>
<td>Extensors of both hands</td>
</tr>
<tr>
<td>62</td>
<td>F39</td>
<td>Lead worker</td>
<td>5 months</td>
<td>10 weeks</td>
<td>16 days</td>
<td>Supinators affected as well</td>
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### Electrical Reactions

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<td>Normal</td>
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<tr>
<td>Lost</td>
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<tr>
<td>Impaired</td>
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### Remarks

- **2 attacks of gout during treatment.**
- **No cause ascertained.**
- **Weakness in deltoid persistent.**
- **Middle and ring fingers first.**
- **Wrist drop twice before.**
- **Facial palsy as well.**
- **Had left works 6 months.**
- **No cause.**
- **Swelling on back of wrist.**
- **In deltoid A.C.C. — K.C.C.**
- **Wrist drop 8 years ago.**
- **Swelling on back of wrist.**
- **Fit 1 month ago, gout since.**
- **In deltoid A.C.C. — K.C.C.**
- **Six attacks of colic.**
- **Mercurialism 20 years.**
- **Atrophic form.**
- **Gout in toes.**
- **Had wrist drop 3 years ago.**
- **Gout every 6 months for 3 years.**
- **Supinator longus affected.**

### Duration

- 2 months: Cured.
- 4 months: Cured.
- 6 months: Cured.
- 8 months: Cured.
- 9 months: Cured.
- 1 year: Cured.
- 5 months: Much improved.
- 2 months: Improved.
- 2 months: Improved.
- 8 months: Nearly well.
- 1 month: Improved.
- 3 months: Little imp'ment.
- 3 months: Improved.
- 6 months: Cured.
- 3 months: Better.
- 3 months: Better.
- 3 months: Better.
- 3 months: Great imp'ment.
- 2 months: Improved.
- 4 months: Nearly cured.
- 2 months: Improved.
- 5 months: Nearly well.
- 2 months: Much better.
- 2 months: Much better.
- 2 months: Improved.
- 1 year: No improvement.
- 6 months: Little imp'ment.
- 6 months: Great imp'ment.
- 1 month: Better.
- 2 months: Improved.
- 2 months: Better.
- 2 months: Improved.
- 2 months: Better.
- 2 months: Better.
- 1 month: Better.
- 2 months: Better.
- 2 months: Better.
- 3 months: Better.
- 6 months: Better.
- 1 month: Better.
- 6 months: Better.
- 6 months: Better.
- 6 months: Better.
- 6 months: Better.
The President said that the thanks of the Society were due to Dr. Eardley-Wilmot for his paper. Records of individual cases were of value, but special acknowledgment was deserved when large numbers of cognate cases were collated and analysed, as in the present instance. Dr. Wilmot had drawn some interesting inferences, which were based on facts supplied, and were not merely sweeping statements evolved from vague experience. Papers of similar form from other members of the Society would be welcome. Probably Dr. Wilmot was correct in laying stress on the lesions in the spinal cord in cases of lead poisoning. A word of caution was due to the public in connection with the medical use of electricity. Great harm might be done by its unskilful employment. Suitable cases for its use should be carefully selected, with regard to the stage as well as to the nature of the disease. The kind of electricity to be used, the exact mode of administration, and the strength in which it should be employed, should be duly considered. So powerful an agent should not be used except under competent medical advice. In some, at least, of the hospitals of Melbourne, better electrical appliances were needed, and more skilful professional administration of electrotherapeutics. In the modern hospitals of Germany, great attention was paid both to hydro-therapeutics and to electrotherapeutics; and, in connection with the excellent bathing establishments, there were well equipped electric baths, which were found useful in many conditions of chronic pain, paralysis or rigidity.

Dr. Gresswell would like to know if Dr. Wilmot had any details to give as to the causation of lead poisoning. He would like to know the occupations of the patients.

The President remarked that their occupations were given in the table which would be published.

The following paper was then read:

ON CYSTO-MYOMA.

By W. Balls-Headley, M.A., M.D. (Cantab.), F.R.C.P. Lond.

The disease which is here considered is of comparatively rare occurrence, and in some of its conditions may be completely differentiated from the ordinary so-called fibroma of the uterus; though in others it may be that the occurrence of the serous fluid is an evolution from a degeneration of the diseased tissue, or even
an excessive local collection of the oedematous exudation common in fibroid tumours.

The term "fibroid" but indifferently expresses the nature of the solid structure of these tumours; and instead of "fibro-cysts," or "cysto-fibromata," it would be more accurate to name these tumours "cysto-myomata," or "cysto-fibro-myomata," according to the predominating character of their structure.

The solid part of the tumour, after maceration in a solution of nitric acid, shows under the microscope the spindle cell of unstriped muscular tissue, surrounding which, and forming the capsule of each individual tumour, is usually more or less fibrous tissue, with connective tissue corpuscles; and on the greater or less proportion of these constituents will the tumour appear red and vascular, pale, or glistening white; the degree of oedema which is liable to be present, and of convexity on section, being due to proportionate vascularity or excessive growth of the internal structure, in comparison with the tension of the capsule.

The sac may be formed by the gradual expansion of lymph spaces, and, after such formation of a cyst, the fluid may continue to be secreted by the cells lining the sac; or by the continuous softening and breaking down of diseased cells, when it is likely that the surface thereof is more of a ragged character, and the fluid contents may or may not be turbid. The inner surface of the sac may be smooth, and lined with cells which produce the fluid contents, or may appear irregular in form, with ragged projections lying in the serum, with flakes of lymph loose, or hanging from these rags. The sac contains a fluid of a rather deep yellow colour, a little dense, usually coagulating on standing, which under the microscope shows unstriped muscular fibre, or it may be degenerating into pus.

The progress of such tumours varies. In some cases, the growth is in itself slow, and may not become serious by its size and drain on the system for many years, while in others the fluid may drain off by the uterine cavity, whereby the size is kept down, though the health may suffer from the continuous loss of albuminous fluid. In such cases as have a smooth lining membrane to the sac, the progress will be dependent upon the rate of development of the serous fluid and solid myomatous structure; while where the lining membrane is irregular with ragged projections and flaky lymph, there is evidence of a rapid progress, and of a strong tendency to break down, and this shortly induces blood-
poisoning. Under such circumstances, it is evident that too much reliance must not be placed on the frequent chronic nature of such tumours.

Cysto-myomata are more frequently met with in the situation known as subserous. The sac may comprise the greater part of the tumour, it may be surrounded by a solid wall of considerable thickness, or it may occupy one side or part only of a large mass of solid myomatous tissue. All the cases of cysto-myoma that I have seen, have been in the unmarried or sterile.

Of the diagnosis, the similarity to ovarian tumour forms the most general difficulty, but pregnancy must always be excluded. The uterus in the cysto-myoma is generally elongated, and if the probe pass high into the tumour, this may be diagnostic from ovarian tumour. The tumour is likely to be central, and apparently on double palpation is the uterus. The fluctuation may be indistinct, and indeed many myomata give a most decided sensation of fluctuation, which experience teaches us to distrust. No doubt the fluid on removal by aspiration would, by its character chemically and microscopically, as showing the fibre cell instead of Drysdale's ovarian cell, decide the question; but I have on more than one occasion failed to draw off fluid where the walls of the sac were so dense as not to collapse, as in the iron shell thrown by a mortar, or where the tube is blocked by a lymph flake. Moreover, it is certainly objectionable to puncture uncertain structures. I have seen a woman die of haemorrhage from the exploratory puncture of a spleen, and the least injury of some uterine myomata in operation may be seen to bleed persistently, as indeed is related below. Opinions on a case will probably differ, and on operation, the surgeon should be prepared to deal with what he meets.

As to treatment, ergot, and the hypodermic injection of ergotine, are remedies which would appear to be most likely to be of service, and I am in the habit of employing them. Such diseases, however, have each their own life history, growing or diminishing as their idiosyncrasy is; and I am not able to say definitely that a case thus cured has occurred within my experience, or even that any distinct alteration was to my mind to be attributed to the drug.

In view of the possible rapidly destructive results to the patient, I should not venture to employ high powers of electricity within the substance of such tumours; and within the cavity of the uterus, I have not seen in such cases appreciable effects.
Of the operative measures, examples of four modes are shown in the annexed cases, and comprise—(1) The removal of the fluid by aspiration per vaginam, and the removal of the ovaries by Battey's operation. (2) Removal of the tumour by "morcellement" per vaginam. (3) Removal of the tumour by laparotomy, and clamping the pedicle by the extra-peritoneal method (extra-peritoneal abdominal hysterectomy). (4) Removal of the tumour by laparotomy, and suturing the stump by the intra-peritoneal method, after Schroeder's plan (intra-peritoneal abdominal hysterectomy). By such operations, or a modification thereof, such tumours are generally treated.

**Case I.**

Miss L., aged 47, for seven years had menorrhagia and very great pain for two days before the catamenia, and an abdominal tumour gradually increased until presently it reached to above the umbilicus. During the catamenia, which would last seven days, with an interval of two weeks, she would use eighteen napkins a day, and in the interval, there was an almost constant flow of serum or loss of yellow clots. I emptied the uterus of these clots, and several times applied liniment of iodine and carbolic acid, solution of persulphate of iron, and iron cotton freely, but ineffectually. At times these clots would project through the os, and appear as if polypi. The tumour gradually increased in size until it reached to the ensiform cartilage, and there was albuminuria. The posterior lip was very thin, and the tumour occupied the anterior lip, cervix, and body of the uterus, and fluctuated. On a trochar being introduced by the vagina through the anterior lip, two quarts of yellow coagulating fluid were drawn off, but the sac refilled in a few days. Having again emptied the sac as before, I opened the abdomen and removed the ovaries and tubes. She made an uninterrupted recovery. The tumour did not refill, the uterus can now scarcely be felt at the pubes, she has since remained perfectly well and strong, and there has been no recurrence of the menses.

The sac evidently occupied the mass of the tumour, and it seems not improbable that when the large quantities of serum and yellow clots escaped from the cavity of the uterus, there may have been some entrance to it from the sac, which subsequently closing, permitted such rapid accumulation of fluid. In view of the complete success of the emptying of the sac, combined with
Battey’s operation, it would seem probable that the lining of the sac was smooth, and capable of immediate atrophy on cessation of ovarian functions. Had it been of loose shaggy tissue, it is rather to be expected that breaking down and septic absorption would have occurred. From such smooth surface, it may be inferred the fluid was directly secreted.

**CASE II.**

Miss W., sent to me by Dr. Woolley of Castlemaine, was 38 years of age. Her first catamenia occurred at the age of 14, and for some years the interval was four weeks, the duration from three to four days with great pain during the flow, and very slight quantity. Was quite well up to four years ago, when the catamenial interval gradually became two to three weeks, the duration seven to fourteen days, with slight pain, and the quantity very large. The abdomen enlarged and gradually increased, and she became thin and weak. There was occasional pain at the right lower abdomen. The abdomen contained a very prominent, firm, apparently fluctuating tumour, extending from the pubes to the ensiform cartilage, of which the walls appeared smooth and regular. The os uteri was high, and lay anterior to a tumour which quite filled the pelvis. The anterior lip was very thin, while the posterior was stretched over the pelvic tumour, which was very low in the pelvis. A whale-bone sound readily entered the canal, and passed upward nine inches on the anterior face of the tumour. The pelvic tumour apparently fluctuated. I introduced a fine trochar into the pelvic tumour, and drew off eight ounces of fluid. Subsequently I opened the abdomen, and found it impossible to remove the ovaries, as they were imbedded in the structure of the tumour.

The recovery from the abdominal incision was perfect; but after ten days the temperature and pulse rose, and fluid being again present in the pelvic tumour, I again introduced a trochar and flocculent pus escaped. Finding the tumour was thus breaking down, I opened into the pelvic tumour by the vagina, through the stretched posterior uterine lip, and by cutting out pieces with scissors, combined with separation with the fingers, enucleation and evulsion, gradually removed the whole of the tumour, leaving the peritoneal sac behind, apparently uninjured. The bleeding was slight, but the shock from the great length of the operation was great and she sank.
The fluid was here situated in the pelvic tumour, while the abdominal tumour was not cystic, but of a glistening fibrous appearance. There were innumerable tumours within the main capsule, some of which, high in the abdomen, were softening and breaking down in their centres, showing fatty semi-purulent contents.

It may be said that it would have been better to operate in the case of such an enormous tumour by laparotomy and the intra-peritoneal method, and I should select this mode had I the same case again; but at the time, the size of the pelvic tumour, the extent of its adhesions, and the debility of the patient deterred me, and indeed I doubt if her strength would have withstood the shock. The removal was only undertaken when the pelvic fluctuation was found to be semi-purulent; but the conditions of parts of the tumour higher up would have caused her death shortly.

The operation by the vagina was much prolonged and rendered much more difficult by a tight hymen and a small vagina, and perhaps in case of the necessity of such operation by the vagina it would be well to divide the perineum in the first instance, and close it at the end of the operation, which I have done successfully in a similar case.

CASE III.

A patient of Dr. Sweetnam, of Mortlake, aged 26, had her first catamenia when 15, with an interval of four weeks, a duration of from four to five days, no pain and a moderate quantity, in which condition it continued to recur up to the operation; except that ten years ago, when she got weak, the recurrence for two to three months was more frequent. Three years ago, she had some anxiety, and got recurrent erythema till four months ago. Two months ago she got a stabbing pain through the lower abdomen, and on two subsequent occasions, when she remained in bed a day. Three weeks ago, Dr. Sweetnam discovered a tumour which he found to rapidly increase. The tumour extended from the pelvis to two inches above the umbilicus—a large rounded mass nearly to the navel, with a large boss projecting upwards from the top of the tumour. It was of a stony hardness, except at a doubtful spot at its centre, a little to the right of the mid-line. The os was soft and normal, and the sound readily passed through the cervix, apparently to the fundus uteri 23/4 inches, with
the concavity slightly to the right, and the abdominal tumour was felt anterior to it. The previous dates refer to my first examination. Four days afterwards, when on the table for operation, the right of the tumour was felt to be distinctly fluctuating, and had lost the sense of stonyness. On opening the abdomen, with the assistance of Dr. Sweetnam, the tumour was found to be highly vascular, and eight ounces of sherry-coloured fluid were aspirated. The tumour was pulled through a long incision by the assistance of a strong cord passed deeply through its substance, an elastic tourniquet passed round its base, and finally Koeberlé's serre-nœud encircled a good cervical pedicle, so that it lay a little above the level of the abdominal wall. A myoma of the size of a large walnut below the level of the wire was tied off, but the site bled, and had to be needled. The ovaries and tubes were separately removed. She had no shock, and made an excellent recovery; the catamenia did not recur. The tumour was highly vascular on its peritoneal surface, under which was a layer of muscular tissue. Below this was fibrous-looking tissue, in the centre of which was a cavity which contained the aspirated serum and flakes of soft saturated lymph. The walls of the cavity were softening and breaking up, forming a ragged lining to the sac.

The regularity of the menstruation is to be remarked, no change having taken place. This increased the difficulty of diagnosis which had differed as to myoma or ovarian tumour; but the stonyness of the tumour, combined with the direction of the uterine canal, pointed to a myoma. The fluctuation at the time of operation was quite marked, and it is probable that breaking-down changes had been very rapid in the previous days, of which the projecting floating shreds and frays and lymph flakes were further evidence. The growth was rapid, and the cystic formation fast spreading.

If it be suggested that it would have been wise to delay operation, it may be answered that the patient was only twenty-six, and therefore, had many years of expectation before the menopause; that her health was failing; that the tumour was rapidly growing; that it would have to be removed at no great distance of time; that attacks of peritonitis seemed imminent; and as the result of examination of the growth, it was seen that septic absorption must have been in progress, and would have been rapid.
CASE IV.

Was thirty-nine years old, had been married twice, and never pregnant. Her first catamenia was at fourteen, the interval three weeks, the duration six to seven days, with fearful pain during the time, and very slight quantity. Eight years ago she found a lump in her abdomen, and began to lose more, so that her catamenia had an interval of two weeks, with a duration of from two to three weeks, with great pain, and the quantity like a flooding. She had pains round her back and limbs, and her head swam.

Reaching irregularly to the level of the umbilicus, and extending into the pelvis, was a very hard apparently immovable tumour. The os was soft, but the cervix was stretched out over the tumour, which there felt softer than that in the abdomen. The sound entered the tumour to the right four inches. The legs were oedematous, and there was albuminuria.

I opened the abdomen, and found the tumour very hard, glistening white, and non-vascular. It was brought well up to the abdominal wound with a strong cord, and a rubber tourniquet was passed round it low down. Wedges of the tumour were then removed, whereby a quantity of clear serum escaped from a sac in its lower level, until it was delivered through the abdominal wound, when it was found that there was no pedicle for the application of a serre-neud. The tumour was found to peel readily from its capsule, and being comparatively non-vascular, it was separated deeply down without much haemorrhage. On the enucleation reaching to the level of the fluid, several vessels had to be compressed with Péan's long forceps. As there was no pedicle, and the tumour extended to the os, it was thus enucleated. Needles and silk were then passed and repassed through a stump formed of the walls of the cervix, and of part of the broad ligaments, out of which the tumour had been enucleated, so that all the tissues were tied in turn, the forceps being removed as the silk was tied. One ovary and tube were embedded in the substance of the tumour, with which they were removed, but the others were tied off separately. A drainage tube was inserted posterior to the stump, and the abdominal wound closed.

The patient made a good recovery, and the catamenia did not recur.

The tumour was of very dense myomato-fibrous tissue in its upper segment, but in the middle and lower segments was breaking down, with shaggy fibrous strips hanging into the serous cyst, of
which the wall at the lower part was quite thin, and was torn through in the enucleation.

On consideration of these various modes of treatment, it will be found that each is adapted to its particular kind. In the first case, the sac was readily emptied, and the ovaries and tubes removed, and the duration of the tumour showed that there was no sudden or rapid degenerative process in action. But in the second case, where the same methods were attempted, neither were the conditions favourable for the performance of these operations, nor if performed effectively from the operative point of view would the case have resulted successfully, for the tumour was breaking down high up. Thus, probably only complete enucleation, and an intra-peritoneal pedicle, as in the fourth case, were the modes of successful operation, and that in the first instance. In the third case, complete removal was the only possible method, and there being a good pedicle, it was taken advantage of, and the extra-peritoneal mode successfully adopted. In the fourth case, the intra-peritoneal stump was only available, but it is an operation which is frequently the most difficult which can be undertaken; and the advantages of suitable light, position of the patient and operator, and special instruments, even for laparotomy, are usually essential.

The general lesson may thus, I think, be well taken to heart—that in commencing a laparotomy, one should be prepared personally and instrumentally, to perform any of the above-mentioned operations as the case may demand.

The President said he was not competent to discuss the more practical issues raised by Dr. Headley's paper, but would notice some of the pathological points suggested by it. Too much might easily be made of the supposed special tendency of unmarried women to myomata of the uterus. Married women were perhaps even more subject to these growths. Sterility was probably the result and not the cause of such formations. It was important that surgeons should remember in what variable degrees myomata were differentiated from the uterine wall. Sometimes they had no distinct capsule, or even seemed like local hypertrophies of the muscular coat. In other cases the capsule was very definite, and perhaps very loosely connected to the growth. He agreed with Dr. Headley that the cystic character was not always a degenerative process of late occurrence, but sometimes an early feature in the developmental history of these tumours. The
extent of the softening process varied greatly. In some instances there was simply a succulence, an oedema, affecting portions of the mass. In others, certain patches became soft and spongy. In others again, irregular interstices appeared between the bundles of fibres, one space communicating freely with another. Such interstitial cavities might attain a great size, and usually had no defined lining membrane. Much more rarely an imperfect capsule was produced, like the thickened wall of a lymph space. The cyst formation was usually very irregular in its distribution, but affected the peripheral more than the central areas of the growth. Sometimes large collections of fluid formed very near to the peritoneum, so that a large cyst might be bounded only by a thin stratum of inelastic tissue, so destitute of elastic reaction that a trochar hole would not close. He had never seen a cyst abut closely on the inner surface of the uterus, never so closely as to suggest the possibility of escape of fluid from the cyst into the uterine cavity. Even the firmest of myomata contained a large quantity of water. If one half of a large tumour were hung up in the air for a few days, it would shrink to a small fraction of its former size, becoming extremely tough and heavy. Probably, the diminution in size of solid uterine tumours produced by electric or other treatment, depended largely on a dispersion of fluid. It was interesting to note in what variable degree the uterus reacts to the presence of fibroid growths. In many cases of submucous or intramural myoma, there was marked hypertrophy of the uterus, with elongation of its cavity. But in some instances of such growth, the muscular wall of the uterus was simply spread out over the tumours, and the uterine cavity not notably increased in size. In some cases of intramural myoma, and in many subperitoneal cases, the uterus was not enlarged or was even shrunk. Sometimes a vast tumour developed from the body of the organ contrasted forcibly with the withered cervix, which formed a kind of pedicle. Many other interesting points suggested themselves, but he felt that he had already trespassed too long on the attention of members.

The following paper was then read:

A COMPLICATED CASE OF RHEUMATIC FEVER.

By B. STEWART COWEN, M.B., C.M., Charlton.

R. A., aged 33 (looked older), publican, had tippled freely for ten years; never any previous illness; stout build and flabby.
Seen October 9, 1891. Ailing for week past. Since previous day, had severe pains in shoulder and right knee joints; sleepless night. Temperature normal, pulse 86. Ordered blisters, with antipyrin and sod. salicylate internally. By evening greatly relieved. Next morning foolishly went outside to stool, and washed himself with cold water; felt sick. Seen shortly afterwards, temperature 100°, pulse 57, markedly irregular in force and rhythm. In afternoon it was 76, and in evening 104. Temperature for next week ranged from 100° to 102°, with pulse 80 to 100, still very irregular. Nearly every joint affected in turn, some repeatedly. Cardiac area not enlarged; heart sounds best heard within and slightly below left nipple; no definite apex beat. On fourth day, and for a week thereafter, friction sound over cardiac area, especially at lower end of sternum and towards the left; no extension of cardiac dulness, nor further obscuration of cardiac sounds. No valvular lesion throughout.

On the seventh day, urine contained one-tenth albumen, this fell to one-sixteenth on the ninth day, and gradually disappeared. On the eleventh day, with temperature over 100°, pulse was 52, with pronounced irregularity both at wrist and over cardiac area, restlessness, and profuse perspiration, especially about head.

October 25 (the last of three hot days).—Mind rambling, and remained confused and weak for next six weeks. Consultation with Dr. McEniry. Temperature 102·5°; pulse 84, regular and good; very restless and sleepless; breathing irregular, suggestive of Cheyne-Stokes respiration; lungs clear until end of November, when there was some congestion of right base.

November 11.—Patient's wilfulness and restlessness have retarded progress constantly. Temperature 99·6°, pulse 94, easily compressible; tongue moist, thick brown coating in middle; mind weak; sleeps well.

November 13.—Temperature normal, pulse 54, irregular.

November 14.—Temperature 100·4°, pulse 100, very irregular. Patient had made his wife prop him up in bed. For several weeks he had a craze for getting up, and actually got out of bed once.

November 25.—Temperature 100°, pulse 107; restless; got out of bed; trained nurse obtained.

November 30.—Temperature 101°, respiration 42; R. M. weak at right base; cardiac action very bad, 116 to 120.

December 1 to 6.—Temperature 99·2° to 101·2°, pulse 96 to 124, still irregular. Vaginal tube in rectum allowed flatus to escape
Complicated Case of Rheumatic Fever.

and gave patient relief; catheter used several times; faeces passed on to sheets; finger, knee and shoulder joints again painful.

During end of November and up to December 17, patient suffered from spasmodic attacks, some of which suggested angina pectoris, while others were distinctly epileptiform in character. They often came on after a drink, with a pain over mid-sternum. Sometimes the face had a painful expression—his face paled, and cardiac action was arrested for ten beats or more. The pallor gave way to a crimson flush which suffused the face. His eyes, which were sometimes drawn upwards, would twitch, and hands and arms move slightly. The nurse reported the legs also moving in some severe attacks, which she said lasted fully a minute, though many of them were over in about ten seconds. Immediately the movements ceased, he would open his eyes and recognise those around him. There was no paralysis. He said afterwards that the whole room appeared yellow and full of smoke during these attacks, and that when a school boy he once had a similar experience and fell down on the road for a moment. After two of the severest attacks the temperature ran up to 103°.

From December 9 to 16 temperature was elevated 100.4° to 102°, sometimes with a very slow (52) irregular pulse, apart from any joint or chest affection. This, with the erratic and occasionally excitable mental condition and the attacks referred to, suggested some cerebral complication, and the possibility of fatty degeneration of the cardiac tissue was also considered.

December 14—Sulphonal grs. xxx at bedtime gave splendid night's rest, and same happy effect was obtained with this drug for next ten nights, patient also resting quietly during the day. From this time progress was uninterrupted, the mental and cardiac condition improved, and in about a month's time patient was able to go away for a change. During his illness he lost four stone in weight.

It cannot be said that drugs—digitalis, strophanthus, nux vomica, bromidia (Battley's solution)—exercised any marked influence over the mental or cardiac condition, except the sulphonal. Of general drugs, bromide of potash with salicylate of soda alternately with quinine gave the best results. About six ounces of brandy were given daily, for a month, combined with egg flip and various peptonised preparations.

(A chart showing temperature, pulse and respiration during whole attack was shown.)
The President said that the case narrated by Dr. Cowen was one of great interest. It was generally recognised that anomalous head symptoms may present themselves during the course of acute rheumatism, sometimes in strongly defined relation to intercurrent pericarditis or endocarditis. When death ensued, meningitis was rarely found. In some instances the valvular lesions had led to embolism, the obstruction perhaps affecting a single large vessel, but more often a number of small ones. But in many cases, in which the symptoms were most peculiar, no definite lesion was found in the brain. The careful record of such cases was of great value, and whenever death ensued, an examination of the brain should, if possible, be made.

The following paper was then read:—

A CASE OF REMOVAL OF A LARGE PIECE OF STEEL FROM THE VITREOUS WITH THE ELECTRO-MAGNET.

By James W. Barrett, M.D.

T. S., aged 29, engine fitter, on December 17, was chipping a counter sink in a steel crank, when a piece of steel flew off and, penetrating the lower right eyelid, entered the globe. The sight was immediately lost, and there was great pain in the eye.

When examined, the fundus reflex was observable peripherally, but in the centre of the eye there was a dark mass, exhibiting a metallic reflex. There was a perforating wound through the lower eyelid, and through the sclerotic below, and to the outer side of the cornea, through which Dr. Honman had seen vitreous exuding. The fine point of a powerful electro-magnet was introduced through this opening into the vitreous, and a piece of metal immediately became attached. The extraction was delayed a little owing to its presentation transversely in the wound, ultimately it was removed. It measured $\frac{3}{8}$ in. in length, by $\frac{3}{2}$ in. and $\frac{3}{4}$ in. other dimensions, and weighed three grains.

After the operation, vision improved for two days till it was $\frac{9}{15}$ partly, then it began to fail, and the vitreous became quite opaque. The eye was fairly quiet, and there was no urgent need for excision. There was, however, some lachrymation in the sound eye, and as it was quite evident vision was hopelessly destroyed, it was deemed prudent to excise it. This was accordingly done eleven days after the date of injury.
The fact that the eye survived such an operation, and that vision was only lost by reason of degeneration of the vitreous, suggests the possibility of saving vision in similar cases, by extracting the foreign body within an hour or two of its entrance.

A peculiar feature of the case was the appearance of apparently spontaneous ecchymosis in the upper lid of the sound eye and its ocular conjunctiva, for which no explanation could be found.

A CASE OF SPECIFIC CHOROIDITIS (? NEURITIS) AND HAZY VITREOUS.

BY JAMES W. BARRETT, M.D.

A young man, et. 31, gave a history of syphilis of five years' duration. His assumption was proved to be accurate by the evidence of his medical attendant. The vision of his left eye had been noticed to be somewhat defective for about twelve months, and to be becoming rapidly worse of late.

When examined, the vision of the right eye was 6/8, of the left 6/17. The optic disc was not distinctly visible, owing to some haziness of the vitreous in front of it. In my note book, at the time, I marked the case neuritis (?) Above, to the inner side, and below the disc were large patches of choroiditis, that is to say, masses of disturbed pigment and of apparent swelling. At that time only one patch showed any signs of cicatrisation or atrophy, the patch to the lower side of the disc; the yellow spot area was not involved.

He was put on the usual anti-specific treatment: Tannate of mercury gr. iii per diem, together with and alternating with potass. iodid. x to xx gr., per diem, combined with vegetable stomachics and tonics.

At the end of five months from the commencement of treatment the vision was 6/8, and the appearance of the fundus had materially changed, as the following description will show:—Left disc swollen and details blurred and indistinct; veins are full, of a red colour, and bend forwards as they proceed outwards over the disc; the arteries appear small by contrast, neither can be called tortuous; the edge of the disc can only be defined at its outer side, elsewhere it merges into the surrounding choroid. To the inner side, and above and below the disc, there is a marked absence of choroidal pigment, so that the large vessels of the choroid are at once distinctly seen. The retina in this part of the field is sprinkled with small masses of fine black pigment lying behind its vessels,
but apparently in front of the choroid. Upward and inward from the disc are two round patches of choroiditis, destitute of vessels and going on to complete atrophy. Downward and inward are three similar patches, one of which has advanced further than the others to atrophy, showing clearly the white sclera. Here and there they are stippled with pigment, but there is no accumulation at their margins. To the outer side of the disc the process is more recent, the choroid is still swollen and opaque, and extending outwards from the disc is a horizontal line of heaped up pigment at the summit of reef of infiltrated choroid. The macula appears to have escaped. To the nasal side the changes extend almost to the periphery, but only two small patches are seen towards the temporal half of the fundus. Opacity of vitreous (?).

Why the vision should have improved, is not quite certain. The probabilities are that there was a neuritis which passed away; but it is equally possible that the cause of the defective vision was a retro-bulbar affection.

The interest of the case lies in this fact, that in four months under anti-specific treatment, whether causally or coincidently, patches of choroiditis passed from an active to a sclerotic and atrophic condition. It is scarcely conceivable that had the loss of vision been due to choroiditis, it would have been restored by the replacement of the choroid, either by atrophied or by scar tissue.

For the notes of these cases, I am indebted to Dr. Webster.

Dr. J. P. Ryan said that five years was a long time to elapse between the primary affection and the appearance of the choroiditis, which was generally looked upon as a late secondary symptom, appearing from three or five months to two years after infection. Even if the case were not syphilitic, he had no doubt but that mercury would be beneficial if the disease were at all active, if there were any effusion; but if atrophy had occurred, it would be of no use.

Mr. Syme had, some years ago, investigated the ocular manifestations of syphilis somewhat carefully. He had been much struck with the very slight effect on vision produced by choroiditis (unless central), and was strongly inclined to think that in this case the defective vision must have been due to neuritis. There did not appear to be any evidence of the actual duration of the choroiditis, although as one patch was atrophic
at the first examination, and the vitreous hazy, the changes may have been present some time; peripheral choroiditis was often difficult to detect. The results of his own experience confirmed Jonathan Hutchinson's opinion, that almost all cases of choroiditis may be regarded as syphilitic.

**Exhibit.**

Dr. W. Moore then showed a specimen of Ruptured Bladder, about which the following notes are furnished:

A man, aet. 53, a groom, was admitted into the Melbourne Hospital on the morning of the 27th December, 1891. The previous day he had been drinking more heavily than usual; in the middle of the night he got up and walked through a second story window, falling on to the asphalt pavement. He was stunned for a few minutes, but was subsequently able to walk. In the morning, before admission, he felt stiff, and complained of pain in the lower part of the abdomen. He passed no urine after the accident, but a little blood came away by the urethra during the night. On admission, the patient was in a semi-conscious condition; he had been drinking heavily for years past, and was scarcely ever sober. Dr. Moore saw him about thirteen hours after the accident. He passed a catheter and drew off a few drops of blood-stained urine. A measured quantity of boracic lotion was then injected, but none of it returned. The man was at once taken to the operating room and anesthetized. An incision from a little below the umbilicus to just above the pubes evacuated a large quantity of clotted blood and fluid. The peritoneum was not opened. The mucous lining of the bladder was readily exposed lying across the pelvis, one torn edge being found on either side. The bladder extended about half way between the pubes and umbilicus, and the tear extended from the summit of the bladder almost to its neck. Fifteen sutures were passed through the muscular coat, leaving the mucous coat free; the lowest portion of the bladder wound was left open for supra-pubic drainage. A drain tube was placed in the lower end of the incision, the rest of which was closed with wire sutures. The urine came away freely through the supra-pubic opening. In three days he passed urine by the natural passage; but his temperature rose and he sank on the fifth day. At the autopsy, the peritoneal cavity was found intact, and there was no injury save that to the bladder. There was a little sloughing of the cellular tissue in front
of the bladder. The bladder-wound, where sutured, was accurately closed; and in the recent state a layer of lymph occluded the unsutured portion of the wound on its mucous surface. The kidneys were in an advanced state of degeneration, being both granular and fatty.

ROLL OF MEMBERS.

The following is the roll of members up to December 31, 1891. Asterisks are placed before the names of those who have been Presidents:

LIFE MEMBERS (21).
Bird, Frederick Dougan, M.B. et M.S. Melb., M.R.C.S. Eng., Collins Street.
*FitzGerald, Thomas Naghten, F.R.C.S.I., Lonsdale Street.
Fletcher, Arthur Augustus, M.D. et B.S. Melb., M.R.C.S. Eng., Lygon Street, Carlton.
*Haig, William, M.D. Maryland (U.S.), Bank Street, South Melbourne.
*Jackson, James, M.D. Lond. et Melb., M.R.C.S. Eng., Collins Street.
Lawrence, Octavius Vernon, M.D. et Ch. B. Melb., Hawthorn.
*Moloney, Patrick, M.B. Melb., Collins Street.
*Neild, James Edward, M.D. et B.S. Melb., L.S.A. Lond.; Spring Street.

ORDINARY MEMBERS (196).
Adam, George Rothwell Wilson, M.B. et Ch. M. Ed., Collins Street.
Aitchison, Alexander Smith, M.B. et Ch. B. Melb., Merton Street, Albert Park.
Aitchison, Roderick, M.A.; M.B. et Ch. B. Melb., Chapel Street, Prahran.
Anderson, T. C., M.A.; M.B., C.M. Aberd., Footscray.
ASTles, Harvey Eustace, M.D. St. A., F.R.C.P. Ed., Collins Street.
Backhouse, John Burder, M.B. et B.S. Melb., Bay Street, Brighton.
Barrett, James, M.D. Syd., M.R.C.S. Eng., L.S.A. Lond., South Melbourne.
Bennie, Peter Bruce, M.A.; M.D. et B.S. Melb., Collins Street.
Black, Archibald Grant, M.B. et Ch. M. Glas., Brighton.
Brett, John Talbot, M.R.C.S. Eng., L.R.C.P. Lond., Collins Street.
Bryant, H. W., L.R.C.P. et S. Ed., Williamstown.
Caffyn, Mannington, M.R.C.S. Eng., Toorak Road, South Yarra.
Campbell, James, M.D. et Ch. M. McGill Univ., Montreal, Moonee Ponds.
Clayton, William Mayne, L.R.C.S.I., L.K.Q.C.P.I. et L.M., Burwood Road, Hawthorn.
Cole, Frank Hobill, M.B. Melb., Rathdown Street, Carlton.
Cowen, B. Stewart, M.B. et Ch. M. Glas., Carlton.
Craig, W. J., M.B. Melb., Ringwood.
Crivelli, Marcel, M.D. Paris, South Melbourne.
Downie, T. Taylor, M.B. et Ch. M. Glas., Clifton Hill.
Duigan, Charles Beamish, L.R.C.P. et S. Edin., Church Street, Richmond.
Duncan, Robert Byron, F.R.C.S. Ed., Kyneton.
Dyring, Carl Peter Wilhelm, M.B. Melb., Coburg.
Eccles, Jacob V., M.D. Michigan, U.S., Collins Street.
Eadie, James, M.B. Melb., Bendigo.
Fetherston, Richard Herbert Joseph, M.D. et C.M. Edin.,
Fetherstonhaugh, Charles, M.B. et Ch. M. Dub., L. et L.M.R.C.S.I.,
North Melbourne.
Fetherstonhaugh, R. Trevor, M.R.C.S. Eng., L.R.C.P. Lond.,
Talbot.
Finlay, William, M.D. San Francisco, Young, N.S.W.
Fishbourne, John William Yorke, M.B. et Ch. M. Dub., Moonee
Ponds.
Fleetwood, Thomas Falkner, M.A. Dub. et Melb.; M.B. Dub.,
F.R.C.S.I., Warrnambool.
Fletcher, Edward, M.R.C.S. Eng., Lygon Street, Carlton.
Foster, Thomas, M.R.C.S. Eng., Colac.
Fyffe, Benjamin, M.R.C.S. Eng., L.R.C.P. Lond., Gore Street,
Fitzroy.
Gaffney, C. Burke, F.R.C.S. Irel., L. et L. Mid. K.Q.C.P. Irel.,
Bendigo.
*Girdlestone, Tharp Mountain, F.R.C.S. Eng., Collins Street.
Grant, David, M.A.; M.D., Ch. M. Edin., Collins Street.
*Gray, Andrew Sexton, M.R.C.S. Eng., Collins Street.
Gray, Charles Edward, M.D. et M. Ch. T.C.D., Auburn.
Cantab., Board of Public Health, Melbourne.
Griffith, James de Burgh, M.D. et Ch. M. Dub., Elgin Street,
Carlton.
Cathedral Hotel, Swanston Street.
Heffernan, Edward Bonaventure, M.D. et B.S. Melb., Brunswick
Street, Fitzroy.
Hodgson, Thomas, M.B. et B.S. Melb., Dandenong.
Hooper, John William Dunbar, L.R.C.P. et S. Ed., Collins Street.
Howard, George Thomas, B.A.; M.D., Ch. B. Melb., Nicholson Street, North Fitzroy.
Hutchinson, Benjamin Clay, M.D. Edin. et Melb., St. Kilda.
Ick, Thomas Edwin, M.A.; M.B. Melb., Essendon.
*Jamieson, James, M.D. Glas. et Melb., Ch. M. Glas., Collins Street.
Jermyn, David, L.R.C.S.I., Port Fairy.
Johnson, F. Miller, M.D., C.M. Ed., Ferrars Place, Albert Park.
*Jonasson, Hermann, M.D. Wurz. et Melb., Collins Street.
Joske, Alexander Sydney, M.B. et B.S. Melb., Greville Street, Prahran.
Kennedy, J. T., L.R.C.P. et S. Ed., Cobram.
Kenny, Augustus Leo, M.B. et B.S. Melb., Collins Street.
Lawrence, H. F., M.R.C.P. Lond., Brunswick Street, Fitzroy.
Lempriere, Charles, M.B., Ch. M. Edin., South Yarra.
Loosli, Robert James, M.B., B.S. Melb., Camberwell.
McCarthy, Charles Louis, M.B. et B.S. Melb., Footscray.
McCreery, James Vernon, L.R.C.S.I., Asylum, Kew.
McLean, Hector Rath, M.B. et Ch. M. Edin., Williamstown.
*McMillan, Thomas Law, M.D. St. A., L.R.C.P. et S. Ed., Toorak Road, South Yarra.
McMullen, J. C., L.K.Q.C.P.I., High Street, St. Kilda.
Martell, H. B., M.B. B.S. Melb., Women’s Hospital, Carlton.
Maudsley, Henry, M.D. Lond., M.R.C.P. Lond., M.R.C.S. Eng.,
    Collins Street.
Meyer, Felix, M.B. et B.S. Melb., Lygon Street, Carlton.
Miller, Hubert Lindsay, L. et L.M.R.C.P. et S. Ed., M.D. et Ch.
    et Mid. Brux., Warrnambool.
Miller, Joseph John, M.B. et B.S. Melb., Sydney Road,
    Brunswick.
    Road, Toorak.
Mollison, Crawford Henry, M.B., B.S. Melb., M.R.C.S. Eng.,
    Balaclava.
Molyneux, John Francis, M.R.C.S. Eng., L.R.C.P. Ed.,
    Williamstown.
Moore, William, M.D., M.S. Melb., Collins Street.
Morrison, Alexander, L. et L.M.R.C.P. et S. Ed., Albert Street,
    East Melbourne.
Morrison, Reginald Herbert, M.B. et Ch. M. Edin., Oakleigh.
Mullen, William Lowell, M.A.; M.D. et B.S. Melb., Collins
    Street.
Naylor, J. H., L.R.C.S. Edin., Hobart.
    Lond., Collins Street.
Noyes, Alfred William Finch, M.R.C.S. Eng., Deniliquin, N.S.W.
    Lond., L.S.A. Lond., Collins Street.
O’Brien, John William, M.B. et Ch. B. T.C.D., F.R.C.S.I., Collins
    Street.
O’Sullivan, Michael Ulich, L. et L.M.R.C.P. et S. Ed., Collins
    Street.
Owen, Frederic James, M.D. et B.S. Melb., Brunswick Street,
    North Fitzroy.
Palmer, George, M.B. Melb., Ararat.
Peipers, Friedrich, M.D. Berlin, St. James’ Park, Hawthorn.
Pettigrew, Augustus Joseph Walford, M.R.C.S. Eng., L.S.A.
Lond., Camperdown.
Pinnock, Robert Denham, M.B. et Ch. M. Glas., Ballarat.
Plowman, Sidney, F.R.C.S. Eng., College of Pharmacy, Swanston Street.
Hawthorn.
Reid, George More, M.D. Edin., M.R.C.S. Eng., L.R.C.P. Lond.,
Castlemaine.
*Robertson, James, M.A. Aber. et Melb.; M.D. Aber. L.R.C.S.
Ed., Collins Street.
Ronald, A. E., M.B., Ch. B. Camb., M.R.C.S. Eng., L.R.C.P.
Lond., Malvern.
Ross, J. B., M.D. Wurzburg, Warrnambool.
Rudall, James Thomas, F.R.C.S. Eng., Collins Street.
Ruddle, Reginald George, M.D. et. B.S. Melb., Daylesford.
Collins Street.
Ryan, Timothy Bernard, M.B. et B.S. Melb., Clifton Hill.
Wellington Street, St. Kilda.
Shields, Andrew, M.D. Edin., King Street, West Melbourne.
Small, John, L.R.C.P. et S. Ed., Geelong.
Smith, Charles, M.D. Lond. et Melb., L.R.C.P. Lond., M.R.C.S
Eng., Casterton.
Yarra Street, Geelong.
Snowball, William, M.B. et Ch. B. Melb., L.R.C.S. et L.M. Ed.,
L.S.A., Victoria Street, Carlton.
Sweetnam, William Francis, M.D. et Ch. M. Q.U.I., Mortlake.
Syme, George Adlington, M.B. et M.S. Melb., F.R.C.S. Eng., Collins Street.
Taylor, Inglis, M.B. C.M. Edin., F.R.C.S. Ed., Exhibition Street.
Tremearne, John, M.R.C.S. Eng., Creswick.
Wall, M., M.D. Munich, Colac.
Webster, Percy, M.D. Durham, M.R.C.S. Eng., Eye and Ear Hospital.
Wilkinson, John Francis, M.B. et B.S. Melb., Bright.
*Williams, John, M.D. Ed. et Melb., M.R.C.S. Eng., Collins Street
Wilmot, C. Eardley, M.B., B.S. Durh., Collins Street.
Wisewould, Percy, M.B. Ch. M. Edin., Bacchus Marsh.
Woinarski, Gustave Henry Zichy, M.B. et B.S. Melb., West Melbourne.
CORRESPONDING MEMBERS (14).

Clutterbuck, James Bennett, M.D. Giess., L.S.A. Lond.
Gardner, William, M.D. et Ch. M. Glas.
Harris, Henry Louis, M.B. et B.S. Melb.
Hunter, C. D., M.B. Glas., L.F.P.S.G.
Kennedy, Patrick, L.R.C.S.I., L. et L.M.K.Q.C.P.I.
Little, Joseph Henry, M.B. et Ch. M. Ed.
Porter, Charles Frederick, M.R.C.S. Eng., L.K.Q.C.P.I.
Poulton, Benjamin, M.D. Melb., M.R.C.S. Eng.
Smith, Patrick, M.D. Syd.
Stawell, R. R., M.B. Melb.
Thomas, John Davies, M.D. Lond., F.R.C.S. Eng., L.R.C.P
Lond., L.S.A. Lond.

HONORARY MEMBERS (11).

Archer, William Henry, formerly Registrar-General of Victoria, Hawthorn.
Black, Thomas, M.D., St. Kilda.
Bosisto, Joseph, Ex-President Pharmaceutical Society of Victoria, Richmond.
Ellery, Robert L. J., F.R.S., Government Astronomer of Victoria, Ex-President of the Royal Society of Victoria, The Observatory.
Maclean, David Purdie, L.R.C.S. Ed., L.S.A. Lond., Williamstown.
Stuart, Thomas Peter Anderson, M.D. et C.M. Edin., Professor of Anatomy and Physiology in the University of Sydney.
Von Mueller, Baron Sir Ferdinand, F.R.S., K.C.M.G., Ph. D., &c., &c., Government Botanist of Victoria, South Yarra.

Messrs. Burroughs, Wellcome and Co. have been awarded First Prize for their "Kepler" Cod Liver Oil, and Compressed Drugs; and Special First Prize for Medicine Cases, at the Tasmanian Exhibition, Launceston, 1891-2.
British Medical Association.

VICTORIAN BRANCH.

ANNUAL MEETING.

Wednesday, January 20, 1892.

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

The President, Dr. A. Shields, in the chair. There was a very large attendance of members.

The minutes of the last Annual Meeting, January 21, 1891, were read and confirmed.

The Hon. Secretary read the Report of the Council for 1891, as follows:—

REPORT OF THE COUNCIL.

Increased prosperity has attended the Branch during the year 1891, and if the meetings had been more regularly attended, the Council would have been thoroughly contented. Members should remember that it would be only courtesy to signify by their presence that they recognise the labour of the gentlemen who prepare papers for the monthly meetings.

Thirty-eight ordinary members were elected during the year, three members died, and five resigned. The number of members at present is 192. This is the largest Branch of the Association outside of Great Britain.

It is with the deepest pain and regret that the Council record the untimely decease of the Honourable George Le Fevre, M.D., M.L.C., who for many years had been a vigorous worker for the interests of the Branch. He was President in 1890, member of Council for 1891, and represented the Branch worthily in England at the Annual General Meeting of the Association, just before his death. The late Dr. Thomas Shearman Ralph was a man of very scientific and studious tastes, and often contributed to the matter dealt with at the monthly meetings. The late Dr. William Armstrong had been elected a member only a few months prior to his decease.

There were twelve Ordinary and two Special Meetings during the year. The latter were called to consider proposals for the amalgamation of this Branch with the Medical Society of Victoria, emanating from the Committee of the latter body. Both meetings rejected the proposals.
Your Council met fifteen times, and the record of attendances is as follows:—

<table>
<thead>
<tr>
<th>Name</th>
<th>Attendance</th>
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<tr>
<td>Mr. A. L. Kenny</td>
<td>13</td>
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<tr>
<td>Dr. Shields</td>
<td>11</td>
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<tr>
<td>Dr. Neild</td>
<td>11 (absent in Berlin)</td>
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<tr>
<td>Mr. G. A. Syme</td>
<td>10</td>
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<tr>
<td>Dr. D. A. Gresswell</td>
<td>9</td>
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<tr>
<td>Mr. Rudall</td>
<td>6</td>
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<td>Dr. J. W. Springthorpe</td>
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<td>Dr. Fishbourne</td>
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<td>Dr. Meyer</td>
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<tr>
<td>Dr. Le Frevre (deceased)</td>
<td>1</td>
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Arrangements are being made for the formation of a District of this Branch at Ballarat. The details will be dealt with by the incoming Council.

In the early part of the year, the Branch endeavoured to have tuberculin scheduled as a poison by the Pharmacy Board of Victoria; but owing to the fact that the composition of, and the tests for, this agent were unknown, the endeavour was unsuccessful. Nevertheless, the publicity given to the discussion by the Press achieved the object desired.

A supper was held at the Vienna Café, on Wednesday, July 22, 1891, at which twenty-five members of the Branch were present. Some very interesting medical subjects were proposed for discussion, and socially and intellectually a most agreeable and profitable evening was spent. The desire for repetition was so unanimous and sincere that your Council recommend to their successors the advisability of holding similar gatherings quarterly.

On the motion of Dr. Neild, Sections were provided for, and rules and regulations for the working of these were drawn up. Although a strong desire was expressed by many for the formation of these Sections, no Section has yet met.

On the motion of Dr. Henry, it was decided that legally qualified medical women should be eligible for election as members of the Branch. The Council of the Association have decided that this is entirely against the rules of the Association.

The following papers were read at meetings during 1891:—

- "Koch’s Treatment of Consumption," by Dr. J. W. Springthorpe.
- "A series of twenty cases of Laparotomy, illustrative of some points in Abdominal Surgery, including a late successful Loreta’s Operation," by Dr. R. B. Duncan.
- "Post-partum Hæmorrhage," by Dr. E. W. Anderson.
"The Story of Photography, and its application to Medicine, with light illustrations," by Mr. L. Hart, Lecturer on Photography at the Working Men's College.


"Brain Tumour," by Dr. G. T. Howard.

"Intra-cranial Suppuration, probably of Traumatic Origin," by Dr. L. Henry.

"Treatment of Hirsuties by Electrolysis," by Dr. H. F. Lawrence.

"Medical Evidence," by Dr. W. L. Mullen.

"Notes on the Colston Case," by Dr. J. W. Fishbourne.


Exhibits at meetings:

Surgical Instruments, by Dr. Hodgson and Messrs. Denyer Bros.

A Sanitary Appliance, by Dr. D. A. Gresswell.

New Drugs, by Messrs. Simpson and Davenport.

Dr. Neild moved the adoption of the report, but wished to make some remarks with reference to the proposals for the amalgamation of the two Medical Societies mentioned therein. It was not necessary to go through the various steps of these proposals. The first one made meant the absorption and obliteration of the Branch, and necessarily he opposed it. The next proposal was more favourable and wholly emanated from the Committee of the Medical Society of Victoria. A Combined Committee of the Committee of the one and the Council of the other Society met several times, and finally carried unanimously a draft of rules and a report in the form of regulations. At a Special General Meeting of the Medical Society of Victoria, called for this purpose, he proposed the adoption of this report and of these rules. He was surprised, and certainly not pleased, at the tone adopted. The attendance was not numerous, but every member had been duly notified. He referred the members to the report of that meeting in the Australian Medical Journal of December 15, 1891. He did not at any time see the absolute necessity for amalgamation, but there were reasons for its desirability. The President of that Society, Dr. Hinchcliff,
spoke sneeringly against the Branch at the Special General Meeting, and declared himself as against amalgamation (vide Journal), yet one month subsequently, at the Annual Meeting of the Society, there was presented the amusing inconsistency of his saying that every one had hoped for amalgamation, and regretted that the various attempts made were unsuccessful. What should one think of such remarks? Thirty-five years ago, there was a feeling that it would be desirable to have a Branch of the Association in the Colony, and Drs. Tracy, Gillbee, and others spoke to him, and at their instigation he wrote articles in that direction for the *Australian Medical Journal* of that time. Of the so-called malcontents, by whom the Branch was said by Dr. Hinchcliff to have been formed, eight were ex-presidents of the Medical Society, and all but one were members of that Society. He (Dr. Neild) left that Special General Meeting of the Medical Society determined to object to the carrying out of any of those proposals, and he was pleased that they were rejected at the Special Meeting of members of the Branch. The majority of the members of the Medical Society would have agreed to amalgamation, but there was a section which objected, and he felt sure that complete harmony would have been impossible. The Branch was strong enough to live, and not only to live, but to flourish.

Dr. W. H. Embling seconded the adoption of the report.

The motion was put and carried unanimously.

The Scrutineers handed in their Report and the Hon. Secretary read it as follows:—Elected—Drs. Kenny, Springthorpe, Gresswell, Shields, Neild, Meyer, Syme, W. H. Embling, and Mullen. For tenth place, Drs. Brett and Hooper tied. Both gentlemen withdrew, and Dr. Molloy was elected. The new Council then withdrew to elect Office-Bearers. On their return, Dr. Kenny announced that the following selection had been made:

*President*—Dr. J. W. Springthorpe.
*Vice-President*—Dr. D. A. Gresswell.
*Hon. Treasurer*—Dr. F. Meyer.
*Hon. Secretary*—Dr. A. L. Kenny.

The Ex-President, Dr. Shields, invited Dr. J. W. Springthorpe to take the chair, and congratulated the Branch on having the right man in the right place, and stated that he had not the
slightest doubt but that Dr. Springthorpe would justify his election.

Dr. Springthorpe thanked the members for the honour conferred upon him, and trusted that his year of office would be a satisfactory one to the Branch. The assistance and attendance of every member was required. If this were given, it could never be said that a few "ran" the Branch.

The Hon. Treasurer read the Balance-Sheet for 1891, and moved its adoption.

The Treasurer in account with the Victorian Branch of the British Medical Association for the year 1891.

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<th>Dr.</th>
<th>£</th>
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FELIX MEYER, M.B., B.S.,
Audited and found correct,
(Signed) WILLIAM HAIG, Auditor.
January 19, 1892.

The motion was seconded by Dr. Brett, and carried.

Dr. Meyer stated that the number of members in arrears had been largely reduced, but that there was still a number in arrears.

The retiring President, Dr. Andrew Shields, then read the

ANNUAL ADDRESS.

Mr. President and Gentlemen,—As it is usual for the retiring President to say something in the way of an address, I have thought that my best plan would be to pass in review some of the leading events which have taken place in the medical world during the past year. It has been truly an eventful year in its medical, as well as in its commercial and financial aspects. Of course, it is chiefly the medical side of affairs about which I intend speaking; at the same time, our own profession, in common with others, and
indeed with the whole community, has felt in a very practical way
the disastrous effects of the commercial depression and financial
collapses which have characterised the bygone year, and has already
associated with it unhappy memories. Amongst other lessons
which the present hard times are teaching us, we are reminded that
the whole community is one body corporate, made up of many
working units, and that the labourer in one field, whether of science,
art, trade or agriculture, cannot say to the humblest labourer in
another department, "I have no need of thee." It does not require a
knowledge of anatomy or physiology to understand how intimately
connected are the members of the body; how each member has
some useful and necessary end to serve, and that they are all so
bound together as to form one co-operative and harmonious whole.
In sound health, as we know, certain groups of muscles, or the
corresponding members on each side of the body, act in concert,
and the lack of such harmony or want of co-ordination, as it is
called, is a manifest sign of disease. What physiologists term
the co-ordination of visual movements, ought to have its counterpart
in the body politic. With a fine Saxon simplicity of language,
Dr. Michael Foster in his "Text-book of Physiology," thus
explains the great principle of co-ordination as observed in
binocular vision:—"If the movements of any person's eyes be
watched, it will be seen that the two eyes move alike. If the
right eye moves to the right, so does also the left; and, if the
object looked at be a distant one, exactly to the same extent; if
the right eye looks up, the left eye looks up also, and so in every
other direction. In fact, the movements of the two eyes are so
arranged that, in the various movements, the images of any
object should fall on the corresponding points of the two retinae,
and that thus, single vision should result." Now it is this single-
ess of vision in a commercial and moral sense, which is so much
required to prevent fatuous, suicidal strikes, reckless speculation,
and financial obliquity. If the eye be single, the whole body
shall be full of light.

I must now, however, pass on to other points which more
immediately concern us on the present occasion; although, I
think, I need scarcely crave your indulgence for having made
these preliminary remarks in this Society, seeing that medical
men, sometimes out of generosity, and, no doubt, at other times
from necessity, have, to some extent, to share the pecuniary
misfortunes of their patients; being the first to be sent for,
and that hurriedly, when some accident occurs, and then, too frequently, the last to be paid, perhaps only in part, or not at all.

The first subject to which I shall refer, is one affecting ourselves as a Branch of the British Medical Association. It is known to you all that during the past year a proposal was made to amalgamate this Branch with the Medical Society of Victoria. The Council of this Branch gave a courteous hearing to the proposal, and a committee, representing each Society, was appointed to meet and ascertain whether a basis for amalgamation could be effected. Friendly negotiations were carried on for awhile, and then the proceedings terminated rather abruptly. It is unnecessary to go into details respecting the reasons which led to such a result, as these were laid before a meeting of the Branch quite recently. It should, however, be clearly understood that the proposal for amalgamation came in the first instance from the Medical Society, and that subsequently the Medical Society was also the first to take up a position which led the Branch to finally abandon all negotiations. For obvious reasons, I avoid details. It is pleasing to be able to say that this Branch has remained loyal to the Association. We have maintained our integrity, and our numbers are increasing. We learn from the Council's report, that thirty-eight new members were elected during the year, and that we now stand the largest Branch outside of Great Britain. It is pleasant to learn all this, but we are also reminded that we have been under the shadow of death, and have lost as well as gained in our membership. Dr. Le Fevre, our genial ex-President, who stood here last annual meeting reading to us his truly valedictory address, is not with us to-night. We remember his buoyant energy, and his kindly, obliging disposition. In these days of doubt and colourless agnosticism, he still held fast the verities of the Christian faith, and though he doubtless did not come up to his own ideal, yet his desire was to be on the side of right and Christian principle. His sun went down while it was yet day, and when he was far from home and family. Coming, as we do, so much in contact with the sick and the dying, we are apt to be less impressed with the occurrence of untimely and unexpected deaths than we ought to be. The words of Sir James Paget, which he does not think it out of place to use in closing his volume of "Lectures on Surgical Pathology," are specially applicable to a case like Dr. Le Fevre's, viz., that "untimely deaths should make us timely wise." Another old
familiar face we shall see no more amongst us, viz., that of Dr. Ralph. He was an enthusiastic worker with the microscope, and like many other workers in science, his patient mental toil was not rewarded with adequate results. His nature was gentle, kind, and unassuming, and his life was blameless and characterised by patriarchal simplicity. After a long life-day of eighty years, the night came in which there was no more working. His death was like a calm sunset, his spirit, leaving the shadows of night behind, entered in through the gates into the City.

One of the events of the past year which may fittingly be reviewed on the present occasion, was that of the Hospital elections. The manner and spirit in which the contest is carried out during the campaign of a hospital election, may to some extent be taken as a test of our medical ethics. It is a kind of standard by which to gauge the candidate's professional honour, good taste, and moral sense; and, as every candidate has friends and admirers, the test becomes comprehensive, radiating out from many centres, and serving as a delicate index to show how the profession carries its honour and upholds its dignity. Hence, the methods adopted by candidates and their followers on such occasions, are a good practical test of our progress in civilisation and good breeding in their medical and ethical aspects. Business relations, favours past or expected, friendship, and even denominationalism, as distinguished from religion pure and undefiled, are all pressed into the service at such times. So much is this the case, that it would most likely be a humiliating revelation if some moral statist or censor morum, could ascertain and publish the number of those who voted for each candidate solely on his professional merits, and as the fittest man for the post. The pressure is often so great, and sometimes of such a delicate nature, as for example, where friendship is concerned, that it would require a strong and courageous sense of duty to stand such a trial, and do what one knows to be the right thing. In fact, it is quite certain, judging from results, which even the ballot box cannot conceal, that, as a community, we are as yet unable to stand such a moral strain as that which the present system of election admits of being put on the subscribers. The principle may be good in the abstract, for it seems eminently fair that those who pay for the support of an institution should have some hand in its management, such as the election of its officers; but then it is not always wise to do what one has a legal right to do.
Many things are lawful which are not expedient. The existing arrangement is so easily abused, and has in fact been so often taken advantage of to serve unworthy ends, that some change should be effected before another election comes round again to demoralize us; so great a temptation should be swept away. A system which admits of a candidate's nationality or religious belief, being openly and vigorously used in his favour; which also allows the money-power and unscrupulousness of himself, or his friends, being made subservient to finding him a place on the medical staff of a public hospital. Such a system requires more than re-modelling and adjustment; it should be removed out of the way, and allowed to fall into oblivion. It must be admitted, however, that there is a great temptation for candidates and their friends to go further than they would approve of in other circumstances. They feel that unless they put forth every effort, some other rival will forestall them. Each one, therefore, in his eagerness to be successful, is liable to be carried away in the strife, beyond the bounds of propriety and honour. The remedy for the evil is a change in the mode of election. An elective body, or committee, would probably be as good a plan as any that could be devised. It would require to be somewhat large, and thoroughly representative. As matters now stand, neither the Churches who contribute generously every year on Hospital Sunday, nor the Government who subsidise liberally, and represent the whole community, have a vote. On the other hand, every subscriber of one guinea has a vote, although many of them give only once in four years. All this would be rectified by appointing a committee to elect, as medical officers, those members of the profession best suited for the position. It would have the further advantage of treating old and tried officers of the staff with becoming courtesy. It would then be enough that they offered themselves for re-election, without having to do all that is implied in soliciting the votes of subscribers. Think of any leading surgeon, physician, or gynaecologist in London having to do such a thing. It should rather be the other way, viz., the hospital soliciting the services of gentlemen whose experience and skill are recognised on all hands. It is unnecessary, of course, to go into details at present, respecting the constitution and character of the committee now suggested, but it may be mentioned in a general way, that if the Council of the Melbourne University, the Committees of the Melbourne and
Women's Hospitals, the Government, and the Medical Profession were fully represented along with the subscribers and the Churches, the Committee would be sufficiently broad and intelligent enough to give satisfaction to all concerned.

Having referred to the University Council, I would here remark, before leaving this part of the subject, that the absence of any practical relationship between the University and our public hospitals is a positive injury to the cause of medical education. Seeing that the University grants a licence every year to a number of young men to practise the healing art, thereby placing them at the very gate of life and death, it is surely an anomalous state of matters that it should exercise no supervision over their training in clinical medicine. Of course, we are aware that clinical instruction is given in our hospitals, but the question is, whether it is done in a regular, systematic and efficient manner. This could hardly be affirmed by anyone fully acquainted with the importance attached to clinical instruction in the best medical schools in Europe, and the admirable provision there made for carrying on such instruction by the most approved methods. The reader of Graves' and Trousseau's Clinical Lectures, delivered even so many years ago, not to speak of the many improvements since their day, cannot but admit that, in respect to the teaching of practical medicine at the bedside, we are doubtless below the standard of modern times. Let it be understood once for all that it is not the lack of ability in the medical staff of our hospitals that is now referred to. We know that in several instances there is marked ability which would be a credit to any hospital, but the real want is that of teachers, properly appointed to carry out a definite and well-arranged course of clinical instruction in a systematic and punctual manner. In order to this, more than skill and experience are required; teaching capacity, and time for doing the work leisurely and well, are also necessary. This can hardly be expected of the busy general practitioner, whose time is so broken up and uncertain that he has usually enough to do to get through the routine of his daily duties with justice to himself and his patients. What, therefore, is found necessary and supplied in the great medical schools of Europe, cannot, without positive disadvantage, be dispensed with here. Our hospitals should be affiliated with the University, and equipped with suitable apparatus for carrying on clinical work. Each ward should have a laboratory supplied with necessary appliances, such as a microscope.
and reagents for examining urine, &c. A professor or teacher of clinical medicine, and also one of clinical surgery, should be appointed; and clinical tutors should give the younger students a systematic training in the clinical methods now recognised as indispensable for accurate diagnosis. As most of our students go directly into practice on getting their licence, and as some of them at least have to carry on their anxious and responsible profession where they cannot readily, or perhaps at all, get the benefit of a consultation, it is clearly the duty of those responsible for their fitness to practise safely and successfully to see that they have had every advantage which modern medical science and experience can reasonably place within their reach. Our friends, the lawyers, are wise in their generation, for, as a rule in all cases of importance, an experienced counsel leads, while the junior counsel assists and learns. How much is one human life, however humble or obscure, of more value than many disputed wills with much property attached?

I shall now refer to another subject which came somewhat prominently before the profession and the public during the past year, I allude to trial for capital offences, and the question of responsibility in those alleged to be suffering from mental disease of some kind. There were no less than seven cases of execution in the colony last year. The plea of insanity is so often raised in defence, that it is no wonder the law is very exacting in the way of requiring direct and positive evidence that the accused is unfit to plead owing to mental alienation. It is well that it is so, and the sacredness of human life justifies the law’s rigid demands. But then it is possible that the law may be too exacting, or too indiscriminate in setting up some ideal test of responsibility, which is either impracticable, or at least does not meet the peculiarities of every case. As a matter of fact, this is notoriously the case in reference to two questions connected with responsibility and mental disorder. The English law holds that a knowledge of right and wrong is the test of responsibility; and further, that a person who is only partially insane, is as much responsible as one of sound mind. Now every medical jurist, and asylum physician and even lawyers themselves, know that the legal theory respecting these two points is wrong, and requires revision. But still it stands on the Statute Book as the law of the land, and hence the constant conflict between illogical, antiquated law, if so it can be called, and progressive medicine. As Dr. Guy justly remarks—
"it is very slowly, and with extreme reluctance, that the law has submitted itself to the teachings of those who have practical experience of the insane." The great difficulty is, to lay down a test of responsibility which will be accepted by legal and medical authorities alike, and which while justly humane, and in accord with the results of modern psychology, will not weaken the law in punishing crime and protecting human life. There is one point, however, which must always remain a difficulty, owing to the peculiar nature of the case. In deciding whether a person charged with murder, e.g., is responsible or not, the difficulty on the medical side is not so much whether the accused knows right from wrong, as whether at the time of committing the deed, he could control himself, and had sufficient power to resist the impulse to do what was wrong. Science can analyse the contents of the stomach in a case of suspected poisoning, or it can calculate the exact amount of strain which a given piece of timber will stand, but who can tell with exactitude the subtle workings of the human mind, manifesting itself through an irritable weakened brain, in the incipient stage of disease. The whole mental process is subjective, and it is therefore sometimes impossible to determine the amount of moral strain which a person, perhaps the inheritor of some neurotic taint or tendency, is capable of standing under a sudden morbid impulse. As is well-known, many persons of unsound mind have a fairly clear perception of what is morally and legally right, or the opposite; but then such knowledge is after all an insane consciousness. It is the consciousness of an insane person, and in judging of such an one's actions, regard must be had not only to his intellect, but also to his will and emotional nature. It is here that the law, and the public generally, fail to recognise the difference between intellectual, and either moral or impulsive insanity. A person with marked delusions is readily admitted to be insane on all hands, but it is otherwise with emotional insanity which, however, is just as real and dangerous although not so palpable and easily recognised. This is a fine field for metaphysical criticism, but I shall refrain from further remarks in this direction, beyond observing that not only does our criminal code require revision respecting the legal test of criminal responsibility, but there is room for improvement in some other directions also. Quite recently a learned judge of our Supreme Court had the honest courage to point out that he felt himself every now and again
placed in an embarrassing position, in having to try cases for which his legal knowledge and training did not fit him. With obvious force and common sense, he urged that equity suits should be tried by an equity judge, and common law actions by a common law judge. I am not aware that he suggested that a judge who tried a murder case, should also have some special fitness for guiding the grave proceedings of a court where a human life is trembling in the balance. This might not be necessary in every case of trying a capital offence, but if the principle holds good in cases of equity and common law, it is only reasonable to apply the same principle in intricate cases of criminal law where the question of doubtful sanity has to be decided. It would also probably lead to a better understanding between the medical witness and the learned judge presiding, if the latter had as good a knowledge of mental science as of legal procedure; and was as well versed in the laws of thought and mental disease as in the law of evidence. Of course, we all respect, and indeed are justly proud of the thorough integrity, patience, and acknowledged ability which characterise our Supreme Court bench, and any one accustomed to attend our courts in cases of trial for capital offence, must have been struck with the shrewdness and acute discernment which the judge has often shown in dealing with even confused or intricate points in medical cases. But on the principle suggested by the learned judge already referred to, both judge and jury, as well as the ends of justice, would be benefited by adopting the course now mentioned. It might help also to rectify the mistaken idea that, because a medical man is licensed to practise, or has some reputation in another branch of medicine, he is therefore qualified to give evidence in cases of obscure mental disease where the gravest issues are involved.

It is greatly to the credit of our profession that it takes such a large and unselfish interest in everything pertaining to the health of the community. Preventive medicine is now regarded as one of the most useful branches of general medicine, and therefore it will not be inappropriate for me to refer to the recent inauguration of the Metropolitan Board of Works, which will make 1891 a memorable year in the history of Melbourne and its suburbs. The great importance of the work which the Board has been entrusted to perform, and the influence of such work, when completed, on the health of the community, can hardly be over-estimated. The absolute necessity of carrying out a well-
designed and properly executed system of sewerage for Melbourne and suburbs has long been advocated by the health authorities, and the futile efforts made by the various local bodies to mitigate nuisances occasioned by liquid refuse which can only be really abated when underground drains are available, is the almost daily experience of every member of this Association; whilst the insanitary custom of retaining, for a week at a time, excretal matter in close proximity to the dwelling under the present pan system, constitutes a danger to health, intensified in the more crowded localities, which can only be effectually removed by a water carriage system. The Board, with its energetic Chairman at the head of a number of business men, and an able, painstaking Engineer-in-chief with his staff, should, we will hope, be able to grapple successfully with the difficulties before them; but it may be observed that, whilst the Board is confronted with problems in hygiene and chemistry not easily solved, the services of neither the medical expert nor the chemist have yet been retained. It is so far satisfactory, however, that before plans are carried out, they must be submitted to the Board of Public Health, and will come under the censorship of our public benefactor, Dr. Gresswell. It is understood that the Board has decided to deal with the whole of the sewage at the outfall by broad irrigation. Except Adelaide, we have had no experience of sewage farming in Australia, but we learn from England and other countries that with suitable land of sufficient area, skilfully laid out, and carefully managed, these farms have been fairly successful. Each one of the conditions now mentioned requires, however, the most careful attention. The Melbourne sewage farm will, I suppose, be one of the largest in the world, and immense volumes of sewage will have to be treated every hour in the day. Then, as compared with England, labour will be much dearer, whilst the selling price of the crops, and especially of fat stock, will have to compete with the cheap production of cattle and sheep fed on the "runs," instead of, as in England, with highly rented agricultural land, and beef and mutton raised on expensive artificial food. The Board, we may assume, has fully considered all these matters, and has selected the sewage farm rather than the ocean outfall for economic, as well as other reasons, and having taken the best expert advice, is justified in following it. Still, I must own to a preference, from a medical point of view, for the ocean outfall, subject, of course, to such a strong direct current
being utilised as would certainly carry away every part of the sewage clear into the depths of the sea, and not, as has been known in some instances, to return along the foreshore, and render the whole neighbourhood insanitary. Referring to details which have been published, it must be admitted that, where ample provision is made for artificial flushing, there can be no doubt as to the wisdom of excluding the bulk of the rainfall from the sewers in a pumping scheme, but the Board has gone further in this direction than Mr. Mansergh, and there is some cause for apprehension that, in the natural desire to reduce the volume of liquid at the sewage farm, "polluted areas" adjoining dwellinghouses may be unduly contracted in such a manner as to leave a considerable amount of pollution outside these areas to discharge into the clear or rain-water drains, and thence direct into the rivers and creeks. The trouble, also, of keeping these two drains on the same premises, each for its special purpose—one for sewage, and the other for rainfall—has been found by those who have had experience of the system to be almost insurmountable; the rain-water channel is too frequently made use of as the housemaid's sink, and when the drains require alteration or repair, the inevitable takes place, and the foul water is connected to the clean water drain. A detail of great importance is sewer ventilation. I understand that in the wide streets and broad thoroughfares, the ventilation of the sewers is likely to be by the method of open grates at the street level—a method, although upheld by perhaps a majority of sanitary experts, has always been consistently opposed by the *Lancet*. One can hardly doubt but that when these grates act as outlets, they emit foul air or sewage gas more or less offensive and, under certain conditions, dangerous. This was greatly complained of by the health officer in regard to the Southport sewers, of which Mr. Mansergh was engineer. The ventilation of sewers seems to be a question not yet definitely settled. Vent pipes as upcast shafts, in conjunction with open street grates as inlets, is a method perhaps as free from objections as any other known at the present time. From a newspaper paragraph, it is satisfactory to learn that the Board intends to have a plan prepared of the whole of the drainage district. If this be drawn on the same lines as the English Ordnance $\frac{1}{100}$th scale survey, it will be extremely valuable. As soon as the main sewers are ready, it may be assumed the private drainage will be taken in hand, and it is of the utmost importance that this work, which will include the construction of water-closets,
traps, air-disconnections, ventilators, &c., should be carried out in accordance with strict regulations, and under the supervision of the Board's officers. House drains are now, in most instances, isolated, discharging into open channels; but when they are connected with the proposed sewage scheme, each house drain will form a part of a vast network of sewers, and unless the private drainage work is thoroughly well executed on the best principles, it requires no prophet to foretell that our last sanitary state will be worse than our first. The water-closet is the only sanitary appliance that removes excreta from the dwelling without delay, but proper construction is essential to wholesomeness, and this, unfortunately, is a kind of work of which few Victorian plumbers have had any experience. Pollution of the Yan Yean water through defective fire-plugs has been clearly shown by Dr. Gresswell, and the risk of pollution will be much increased under the water-closet system; but this, no doubt, will be guarded against by the Board insisting on the use of service boxes, or intercepting cisterns for the supply of water to the closets, urinals, and public conveniences, &c.

Hitherto I have confined my remarks to events which have occurred within our colonial experience, but there is a wider circle embraced in the medical periscope of the past year. In common with the whole civilised world, we have been visited with the influenza, and questions as to its origin and mode of spread are being raised anew. The recent pandemic has shown very clearly how little the weather, and especially the temperature of the atmosphere, has to do with its prevalence. We learn by telegraph that, during the present month, it has continued to spread and manifest itself in a severe form in Great Britain and various parts of Europe and America; and when we remember the temperature which obtains in England, the northern parts of Europe, and in America in the month of January, and compare it with our genial Australian climate, where the disease has also prevailed extensively, we are in a position to judge how little this scourge is influenced by the conditions of the weather, or the seasons of the year. This same feature, viz., the negative influence of the weather, has been also specially observed in the history and spread of former epidemics, and might be illustrated to a great extent, but this is unnecessary on the present occasion. While we have yet much to learn respecting the true nature of influenza, one thing is almost conclusively established, viz., that its home is
in the East, probably China, just as India is the home of cholera. For, although it is sometimes called Russian influenza, the Russians themselves give it the name of Chinese catarrh. Arising in the East, its tendency is to spread Westward, and one of the most interesting points connected with the recent epidemic is given in the British Medical Journal of August 29th, 1891. The account is written by Dr. Cantlie, of Hong Kong, and entitled, "The First Recorded Appearance of the Modern Influenza Epidemic." This history of the first appearance of the present outbreak is particularly valuable, as it is written by a medical man resident in China. Dr. Cantlie records the important fact, that the disease appeared in Hong Kong in September and October 1888, and that it seems to have travelled across Siberia and reached St. Petersburg in 1889. In short, he contends that influenza is endemic in China, and that the prevalence of the disease in Hong Kong towards the end of 1888, was the starting point of the recent epidemic all over the world. But while it is generally agreed that it originates in China, much difference of opinion exists as to its mode of spread. The revival of an old theory, viz., that influenza spreads by contagion, is now being vigorously maintained. This view has been accepted by Klein and others, but it can hardly be regarded as accounting for all that is known, not only from the present, but also from former epidemics, respecting the suddenness of the invasion, the very large numbers, literally thousands, simultaneously attacked, the apparent capriciousness of its course, and the extreme rapidity with which it spreads. Even cholera is "slow and halting" in its march compared with influenza. Then, if contagious in the ordinary sense, an incubation period has to be taken into account and allowed for when considering its rapid spread, and the great numbers attacked at one time.

I cannot, however, prosecute the subject further, and I have already detained you quite long enough. What we require in regard to influenza and some other allied subjects, such as cholera, yellow fever, malaria, and even diphtheria and typhoid fever, is less speculation and more accurate scientific observation. A spirit of critical inquiry is abroad, and more exact and reliable methods of observing and recording now obtain than in former epidemics. Bacteriology also comes to our help against the great invading army of microbes, and therefore we may expect a harvest of valuable results from the recent epidemic such as never could have been obtained in former times.
In conclusion, Gentlemen, I beg to thank you for your patient hearing on the present occasion, and especially for giving me the seat of honour amongst you during the memorable year of 1891.

The President, Dr. SPRINGTHORPE, felt that he was expressing the feelings of every one present in proposing a hearty vote of thanks to Dr. Shields for his admirable address. He had dealt with a large number of topics, and some of them he treated as an accredited expert in this colony. It was out of place to dwell critically upon what was said, but many men have different opinions. What had been said would carry weight, and would be followed by good results. As Government Medical Officer, and as an ex-Officer of Health, Dr. Shields was well qualified to speak of lunacy and health matters. He would endorse his opinions on lunacy reform, and he believed that a large number of medical men shared Dr. Shields' views as to the danger of water carriage in the sewerage system. Regarding Cantlie's claiming Hong Kong as the birth-place of influenza in 1888, it should be noted that we had had one epidemic in 1885, and for the two or three years subsequently there were epidemics of severe influenza throughout the whole of Melanesia.

Dr. NEILD had much pleasure in seconding the vote of thanks. He had been on the Council of the Branch with Dr. Shields for some time, and could testify that the harmony of the proceedings was greatly facilitated by the genial kindly way in which he presided.

The motion was carried with acclamation.

Dr. SHIELDS, in reply, thanked the members. In his address he had not had time to finish his ideas on influenza. He had not clearly and well made up his mind on certain points, and would be pleased to meet persons who could enlighten him thereon. He took it as a very great compliment to have been their President for 1891. He was not so vain as to think it was on his own account solely that they had chosen him, for he felt that they had regarded the official Government position he held.

The meeting then terminated, and Dr. Shields entertained the members at a recherché supper at the Vienna Café, in Collins Street.

Dr. Hall-Owen has been elected honorary surgeon to the Benevolent Asylum.
Nearly two years ago, a paper on "The Abuse of Hospitals and the Lodge System" was read before the Medical Society by Dr. Barrett, but as he only incidentally and briefly referred to the Lodge System, many members expected that the subject would be discussed at length on some future occasion. No such discussion has yet taken place, although references to the system have been made in the last two presidential addresses, and the lay press has contained some correspondence concerning it. The subject is one of vital importance to a large proportion of medical men, and might very profitably be discussed by the Society, and some organised effort made to secure reform by uniformity of action.

Lodges appear to be a necessity. There will always be a large proportion of the community who cannot afford to pay the ordinary fees, even if reduced, as Dr. Hinchcliff suggests, and yet are not paupers or fit subjects for hospital relief.

Admitting that Lodges must exist, the question is—Are they managed in the best way, and are the relations between them and the profession the best possible? The first complaint concerning Lodges is that they, like the hospitals, are abused. Dr. Barrett's statement was that a minority of members of Lodges are well able to pay ordinary fees. Dr. Hinchcliff goes further, and says "the members' roll of societies generally consists . . . largely of men whose positions in life, whose yearly earnings and whose status in society ought to, but does not, preclude them from availing themselves of the services of a club doctor." The actual facts as to the extent of this abuse ought to be readily ascertainable, and further, it ought not to be a difficult matter for the profession to insist that the abuse be stopped, if medical men would only combine.

Dr. Jackson drew attention to another aspect of the subject. "Few influences," he said, "have more signally
tended to degrade the dignity of medicine than club practice, as it obtains in this part of the world." The beginning of a practice by taking clubs is "made very often under circumstances which involve a renunciation of self-respect." Dr. Hinchcliff is of the same opinion. According to him, the Lodge surgeon is "compelled to render obsequious service, and often to do violence to his feelings and self-respect, by degrees becomes indifferent, and performs his duties in a perfunctory manner."

While these remarks may be perfectly true in individual instances, there is an implied assumption in them concerning the relations necessarily subsisting between Lodges and their medical attendants, which is not fair to either, and cannot be permitted to pass unchallenged. A man may be medical officer to a Lodge without in the slightest degree doing violence to his feelings, or sacrificing his self-respect, and it can be proved by actual experience that, if members of the profession respect themselves and maintain their own dignity, at the same time that they faithfully discharge the duties they undertake, the members of Lodges will respect them also, and treat them with becoming consideration. There are not a few who affect to despise Lodge practice, and regard it as degrading, but they forget that honest professional work, conscientiously performed, can never degrade. It is not the position that is degrading, but the conduct of the men who hold it. The artifices of fashionable practitioners, the electioneering tactics of candidates for hospital appointments, the propensity for advertising of men holding what ought to be high positions, are all as degrading as any of the relations between medical men and Lodges.

The real evil, as Dr. Hinchcliff himself sees clearly enough, is not in the Lodge System, but in the keenness of competition—in the fact that the supply of medical men is greater than the legitimate demand. Every year increasing numbers of practitioners are registered, and as most of these have no private means, in order to gain a bare means of subsistence, they are driven to touting for Lodges on lower and lower terms. As expenses increase, they take more Lodges, until it is often impossible for them to give anything like adequate
attention to their patients; they find they are mere drudges, lose their own self-respect, and the respect of the Lodges also.

Remedies for the evils are not easily suggested, or if suggested, are not easily put in operation. It is easy to say that the number of medical practitioners must be limited, but how? The immigrant stream from abroad might perhaps be somewhat checked, by announcements in Great Britain as to the keenness of competition in the colonies. Local production might perhaps be somewhat limited by raising the standard of examinations, and lengthening the curricula in the Colonial Universities. The discussion of the difficulties will help to educate public opinion, and deter the rising generation from entering an overcrowded profession.

But these measures will not alter the fact, that the profession is already overcrowded. In the commercial world, overproduction means a fall in prices. So here, members of the profession will have to be content with lower fees, and smaller incomes; they will have to leave the large centres of population and settle down in country districts where their expenses will be less; they will have to protect themselves by union against the abuse of charitable institutions and benefit societies. In short, the remedies lie almost entirely in their own hands.

**Vital Statistics.**

The Government Statist's report of the vital statistics of Melbourne and suburbs for December 1891, shows that the births of 1489 children, viz., 736 boys and 753 girls, were registered. The deaths registered numbered 897, viz., 467 of males and 430 of females; the births thus exceeded the deaths by 592. To every 1000 of the population of the district, the proportion of births registered was 3.03, and of deaths registered 1.83. One hundred and thirty-one deaths, or 15 per cent. of the whole, took place in public institutions. Of those who died, 406 were under one year, the total number under five years of age being 483. In December, as compared with the previous month, a considerable increase took place in the mortality from diarrheal diseases, the number of deaths being 82 and 54. Typhoid fever, moreover, caused 17 deaths against 3, and whooping cough 16 against 12. On the other hand deaths from influenza, combined with deaths from diseases of the organs of respiration, numbered only 80, as against 154 in November and 503 in October; and deaths from diphtheria numbered 10, as against 11 in November and 7 in October.
Local Subjects.


HEALTH OFFICERS.—The following appointments have been confirmed:—Shire of Towong—Edward Harkness, L.R.C.S., vice Johnstone Simon Thwaites, M.B., resigned; Shire of Arapiles, North Riding—Johann August Weber, M.D. (Acting Officer of Health), vice James Purves White, M.B., resigned; Shire of Moorabbin, South and West Ridings—George Oglo Moore, M.R.C.S., vice Herbert William Steele Verity, M.R.C.S.; East and North Ridings—George James Scantlebury, L.R.C.P., vice Herbert William Steele Verity, M.R.C.S. Analyst—Shire of Benalla—John Nicolson, M.D.

Dr. Mollison has been elected Honorary Pathologist to the Women's Hospital, in the place of Dr. Syme, resigned.

For the position of specialist for diseases of the skin at the Alfred Hospital, vacant by the resignation of Dr. Elsner, there were seven candidates. A ballot took place, and Dr. A. W. F. Noyes was declared elected.

The following is a summary of the Coroner's Constable's return, showing the number of inquests held during the past year, with the causes of death, discriminating those in which drink played a prominent part:—Suicides—general 16, drink 18; Accidents—general 113, drink 29; Murders—general 23; Manslaughter—drink 1; Executions—general 4; Miscellaneous—general 85, drink 50; Fire—general 1.

BIRTHS.

Fox.—On the 29th December, at York House, Brunswick Street, North Fitzroy, the wife of William R. Fox, L.R.C.S., L.R.C.P. Edin., of a son.

Keogh.—On the 14th ult., at Barkly Street, St. Kilda, the wife of Arthur G. Keogh, M.B., C.M., of a son.

Salmon.—On the 30th ult., at Ballarat East, the wife of H. R. Salmon, M.B. et Ch.B., of a son.

MARRIAGE.

Kenny—O'Connor.—On the 13th ult., at St. Patrick's Cathedral, Melbourne, at a nuptial mass by the Most Rev. Thomas J. Carr, D.D., Archbishop of Melbourne, Augustus Leo Kenny, M.B., B.S., K.S.G., eldest son of Mr. John Kenny, of Franklin Street, West Melbourne, to Frances, fourth daughter of Mr. Nicholas O'Connor, of Illapa, Princess Street, Kew.