Present: Dr. McMillan, Mr. Gray, Dr. Jamieson, Dr. Hunter, Mr. Gillbee, Dr. Graham, Dr. Molloy, Dr. Williams, Dr. Martin, Mr. Pincott, Mr. Rudall, Dr. Neild, Dr. Colquhoun, Mr. Rae, Mr. Barker, Dr. Jonasson, Dr. Bowen, Dr. Hinchcliff, Dr. Ryan, and Dr. Webb. Dr. W. Reid, Staff-surgeon of the Wolverine, was present as a visitor.

The President, Dr. McMillan, and afterwards Dr. Graham, the senior Vice-president, occupied the chair.

NEW MEMBERS.

Dr. Charles Schleicher, of Collins-street, and Dr. T. A. Garlick, of the Melbourne Hospital, were elected ordinary members.

EXHIBITS.

Dr. Williams exhibited Mayer and Meltzer's Combined Voltaic and Induction Coil Battery, and Dr. Jamieson exhibited a new Stöhrer's Battery.

The following paper was then read:

ON RUPTURE OF THE PERINÆUM.

BY JAMES JAMIESON, M.D.

Talking once with a practitioner of more than thirty years' standing, he volunteered the statement that he had never met with a case of ruptured perinæum, even of the slightest degree. This experience differed so completely from my own, as well as from that of many of the best authorities on obstetrics, that I had no

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choice but to conclude that my friend had seen no ruptures of the perineum, simply because he had not made right use of hands and eyes so as to discover them in the course of his midwifery practice, which I knew to have been considerable. Other circumstances have also led me to the belief, that this subject does not always receive by any means the attention which its importance demands. In the earlier years of my own practice, I must confess that I was not sufficiently alive to the seriousness of this question, and perhaps the reason, in my own case, as in that of others, is the slip-shod, perfunctory manner in which it is discussed in most systematic works on midwifery, and especially the older ones. Statistics of the frequency of rupture of the perineum due to the passage of the child in labour, are scarcely to be met with in English medical literature. Professor Simpson, in a short paper in his obstetric works, states that ruptures are much commoner than is often supposed, and that they cannot always be prevented by any precautions. Dr. Snow-Beck, in the Medical Times in 1856, gave the number of ruptures of all degrees, at no less than 66 per cent. of cases of delivery. This gives such a high figure, that it can only be explained on the supposition that he included even the smallest cracks or fissures. More exact details have been afforded by some foreign writers. Thus Schroeder, in his "Text-book of Midwifery," which has been translated into English, states the result of his own exact observations to be, that in primiparae the frenulum is torn in 61 out of every 100 cases, and that actual perineal ruptures are found in 34½ per cent. of these cases; whilst in multiparae the frenulum gives way in 30, and the perineum in nine out of every 100 cases. The reports of the St. Petersburgh Lying-in Hospital show results very similar to those of Schroeder. Better results than these, however, have been published. Thus, Professor Winckel of Dresden gives 11.5 per cent. as the proportion in all cases, and Professor Olshausen, of Halle, 21.1 per cent. for primiparae and 47 per cent. for multiparae. I have not kept any details of my own cases, so as to be able to give exact figures, but I do not think that my experience is so bad as some of these, though undoubtedly I have seen a considerable proportion of cases, and especially in women who are delivered for the first time, when 30 years of age and upwards.

As to the precautions to be taken for the prevention of rupture, I need not say much, as details are given in all treatises on midwifery. The general principle is to keep back the head, so as to allow of the gradual dilatation of the parts, and, what is of great importance, though not so generally insisted on, by means of one or two fingers in the rectum, to press the head of the child well forward against the symphysis as soon as the occiput has fairly passed beneath the arch. It is probable, too, that position has a good deal to do with the prevention of rupture in many cases of normal delivery. If the woman inclines well forward when the head is in the act of passing, the proper bending back of the head is more likely to take place, and thus a smaller diameter of the head will occupy the outlet.
Ruptures, no doubt, generally occur at the moment when the perineum is stretched to the utmost by the passage of the child's head, but my experience has proved to me, that even after the head has passed with safety, there may still be considerable danger if great care is not taken in the evolution of the shoulders. This is perhaps especially the case when the mucous membrane of the vagina has given way on the posterior side just above the outlet. My practice recently, in doubtful cases, has been to keep back the shoulder which lies posteriorly, until I have brought down the other arm, so that the thorax is pressed up into the pubic arch when the posterior shoulder glides over the perineum, a considerable saving of space being thus gained. I think that the introduction of one or two fingers between the shoulder and the perineum, may often tend to the preservation of the latter. I have never used incisions on either side of the outlet as a prophylactic measure, though they are strongly recommended by many authorities.

Since I have become convinced of the frequency of rupture, I have made it a habit, as soon as delivery is completed, to examine carefully the state of the perineum by means of one finger in the vagina and the thumb outside; and if the loose stretched perineal structures could not be felt with certainty to be entire, at once to make an ocular inspection of the parts.

Even when a rupture is found, many hold that it is not necessary to apply sutures, unless the separation of parts is very extensive, involving the muscular structures, and that it is sufficient to enjoin rest for a longer period than usual, with the knees kept together. Formerly I contented myself with the same measures, though of late years when there is a rupture of the skin extending for any distance behind the frenulum, I have regularly introduced wire sutures. It may be that an enlargement of the vaginal outlet does not necessarily lead to prolapse of the pelvic organs, but it cannot be doubted that if the outlet is abnormally patulous at the expense of the perineal fold, those organs cannot receive proper support from below, and will thus more readily subside either from gravity, or as the effect of straining or other efforts.

I do not think there is so much difficulty in bringing together the ruptured parts as is often thought. The method which I have adopted is to cleanse the parts by injection, to remove with the scissors any small ragged portions of tissue, and then by means of a long curved needle to introduce as many deep silver-wire sutures as may be necessary. If the rupture extends for any considerable distance upwards, it may be advisable to use one or more superficial sutures in the vaginal wall, so as to prevent burrowing of matter behind the deep sutures. My best results have been attained where I used the catheter with my own hands twice, or oftener, in the twenty-four hours for several days. I leave the sutures in for at least a week. On both these points there is difference of opinion among authorities, some saying that the use of the catheter is unnecessary, and that it is better to remove the sutures earlier, even at the end of two days. I have also been in the habit of
giving opium to cause constipation for several days, but I observe that very successful results have been attained where the bowel was cleared out every day by an enema of luke-warm water. The special advantage claimed for this method is, that by preventing constipation there is less danger of any febrile condition being produced. The difficulty attending it, however, is that the giving of the enema must often be entrusted to a nurse, and she cannot always be depended on to be delicate enough in her manipulations. In the last case in which I applied the sutures, I carried out strictly the antiseptic method lately introduced in some lying-in hospitals, and was struck with its advantages.

Dr. Jonasson would like to know how soon after the rupture the operation should be performed. He thought unless the rectum were injured, there was no need for operation at all. There was always an objection to this operation, in that the very suggestion of its necessity conveyed to the patient or her friends, the impression that there had been some neglect. The exhausted condition of the patient, too, increased its undesirableness. Reliable authorities, moreover, had asserted that, during the first week after delivery, it was not effectual. He believed that most perineal ruptures would heal of themselves if left alone.

Mr. Gillbee thought it was always best to perform the operation at once. There was not only the woman herself to be considered, but her husband. He believed very few women would object to the operation when its advantages were properly explained to them. They were sure to know if they were ruptured, and it was much better honestly to tell them they were, than leave them to discover it. There was always more difficulty in its performance after the parts had been subjected to the passing over them of the secretions. It certainly obviated the risk of prolapsus uteri, and the large vaginas, which, for many reasons, were so undesirable. He had performed it several times, and he was satisfied that when done immediately after the injury, and when the parts were numb and not sensitive, the woman suffered far less than afterwards.

Dr. Martin had been surprised by the statistics furnished. He had never heard of in British practice, and he had certainly not seen in his own, any such frequency of perineal rupture as Dr. Jamieson had stated to exist. To be sure, they included all kinds and degrees. Where there was only a simple rupture of the mucous membrane, there was certainly no need for operative interference, but when the skin was divided, a suture was imperative, and that within a few hours. If left twenty-four hours there could be no chance of first intention healing. He approved of the operation being done at once, and every medical man ought always to be prepared to perform it. The kind of suture was somewhat important. He did not use silver-wire, but only silk or horsehair. For on the third day, with wire or silk, there was sure to be a track of pus. This result did not follow the use of horsehair. Dr. Bantock, of London, had written to him recommending silk-worm
catgut, that is, such as was used for fishing-lines. He (Dr. Martin) had tried it, and had been disappointed with it. Mr. Spencer Wells had used twisted silk. He could not, however, too strongly urge the immediate performance of the operation, for if delayed there was sure to be a long and painful process of healing. It was a solemn duty to put in the sutures at once. On the question of leaving the bowels open, he quoted the case of a practitioner who had delivered a woman with forceps. There was a laceration through the recto-vaginal septum halfway up. Wire sutures were put in, and on making an examination in the afternoon, the vagina was found to be full of faeces. Of course, an entirely fresh operation had to be done. As to the prevention of this injury, he did not think the pressure of two fingers in the rectum justifiable. The same kind of pressure could be exerted equally beneficially externally. Neither could the dilatation be advantageously helped by the insertion of two fingers to pull back the perineum. Where the rupture could not be avoided, rather than allow it to take place in the raphe, a small incision with a bistoury on each side might be had recourse to. These incisions could be brought together afterwards by a suture. When the operation was not done immediately, a period of at least six weeks should elapse before it was attempted, otherwise good union would not be obtained.

Dr. Molloy pointed out that when the child had to be extracted by force, it was not possible to insert two fingers.

Dr. Hunter had found fomentations to soften the parts and help to prevent rupture.

Dr. Ryan spoke in favour of the use of horsehair sutures.

Dr. Bowen, when resident in the Dublin Rotunda Lying-in Hospital, remembered that Dr. Denham used to order women to be delivered on the back, as a means of preventing perineal rupture.

Dr. Jonasson, in explanation, desired to say that although he did not pretend to object to the performance of the operation when required, was yet strongly of opinion that a medical man, and especially a young man, might do himself much harm by a too great readiness to operate.

Dr. Jamieson, in reply, had brought up the subject principally for discussion, and because he did not think it had previously furnished a subject for consideration by the Society. He did not presume to instruct those who had the right to be considered specialists on such subjects. He wished, moreover, to combat the pestilent heresy of doing nothing. It was the commonest thing in the world for practitioners to find the vagina extending almost to the anus, and this, he thought, ought not to be. Prolapse could not but be the result. With reference to the frequency of the accident, it was somewhat difficult to get at statistics in English obstetric literature. Simpson spoke of its occurring very frequently. Snow-Beck said it occurred in 66 per cent. He did not doubt the
advantage of using silk sutures; there was always a difficulty in removing those of wire. As to the necessity of performing the operation, he thought there could hardly be a difference of opinion. Concerning the use of opium, some experienced authors spoke of generally good results without its use. He thought, by common consent, it was agreed that old primipare were more liable to the rupture than young ones. He was in the habit of introducing two fingers into the rectum, and he thought this mode had the advantage over external pressure. In reply to Dr. Martin, he did not advocate pulling back the perineum; what he had said was that he inserted two fingers between the shoulder and the perineum. He did not doubt that a slight incision at the sides might occasionally be useful, but he had not tried it. An average practitioner would hardly venture what a specialist might do, but would hope the perineum would hold on.

EXHIBIT.

Dr. Hinchcliff exhibited the petrous portion of a temporal bone, in which there was a tumour, probably of a steatomatous nature. The history of the case was as follows:—

John Henderson, aged 62, admitted to the Bendigo Hospital October 25th, died October 27th. He had been taken ill suddenly three weeks before, with pain in the left ear and side of the head, and noises like an engine working. He became a little better up to the period of admission. He was then very pale, with a thickly furred tongue. The pain increased up to the 27th, when he became insensible and remained so for 16 hours, when he died. Post mortem examination showed extensive meningitis as the result of the tumour.

The following paper was then read:—

NOTES OF THREE CASES OF POPLITEAL ANEURISM TREATED IN THE BENDIGO HOSPITAL.

BY E. HINCHCLIFF, M.D.
Resident-Surgeon to the Bendigo Hospital, Sandhurst.

The treatment of popliteal aneurism has always been a subject of controversy amongst surgeons, and at present many views are held as to the best method to be employed. Having had three cases under my care during the past twelve months, I am induced to bring the notes of the case under the notice of the Society, so that the subject may be thoroughly discussed.

I will not take up the time of the members by entering into the pathology of this too prevalent affection, but will make a few remarks as to the treatment employed.

In the first and second cases, flexion of the limbs was tried for a period over a week, with little apparent result. In the second and third cases, pressure was made on the femoral artery by means of a bag of shot, made in the shape of a cone, weighing about five
pounds, the pointed end resting on the vessel. This treatment I adopted, not so much with a curative view, as with the object of slowing the current through the main vessel, and thus promoting the establishment of the collateral circulation, prior to cutting off the blood-supply to the limb by operation or otherwise. The importance of such treatment cannot, in my opinion, be over-estimated, as by this means we reduce the dangers due to defective blood-supply almost to a minimum, and lessen the amount of pain and swelling so common after ligatures of the vessel. Again, many cases are on record where partial, if not absolute, consolidation of the aneurism has been produced by such means. Objection may, no doubt, be taken to this mode of treatment, that the too free collateral circulation at the time of closing the artery by operation may be a source of danger, on account of the possibility of the clot, when formed, being dissolved or broken down by regurgitation of blood through the distal portion of the vessel; but when we consider the minute anastomosis by which the circulation is carried on, and the smallness of the vessels leaving the artery near the seat of aneurism, I think we may safely dismiss the idea from our minds.

I next tried mechanical and digital pressure on the first two cases, for periods of over twelve hours continuously, and, though no good was produced, I am rather inclined to attribute the failure to imperfections in carrying out the details. At the same time, it is evident that the difficulties of maintaining absolute stasis in the sac by pressure on the vessel, is greater in some cases than others, due to the anatomical position of the vessel, so that it is often very difficult to compress a vessel in Scarpa’s triangle. In my third case I found the vessel was much more easily compressed than in either of the previous ones, and it is a significant fact that he had been cured of aneurism on the other leg by digital pressure alone. Dr. Paterson, of Glasgow, records a case in the *Lancet*, June 30th, 1877, where he cured aneurism on both legs of a patient by digital pressure alone—one in twelve hours, and one in nine hours.

Having failed so far, I next proceeded to ligature the femoral artery in the thigh, and in both cases I carried out the operation as closely as possible in the manner advocated by Mr. Lister. A spray of solution of carbolic acid was played over the part during the whole operation. I tied the vessel in both cases with a ligature of catgut, specially prepared by myself more than two years ago, by soaking it in a mixture of carbolic acid and olive oil, in proportions of one to seven, in which mixture it was kept until wanted. The ends of the ligature were both cut off short, the wound closed with catgut sutures, and dressed with carbolic oil and lint, as I had no prepared gauze.

In the first case union by first intention took place, and the second case was prevented from doing so by the presence of a drainage tube that I left in the wound, owing to a slight bleeding taking place after it was closed, which I feared might set up irritation if no escape were left. Ligature of vessels after this manner, appears to me to be much more safe and effectual than the ordinary manner by
hempen ligature. In the former, the vessel is not cut through, the remains of the ligature in the wound, whether they become absorbed or encapsulated, cause no irritation, and the absence of putrefied suppuration is in itself a decided benefit; while in the latter the presence of a hempen ligature is a source of danger by setting up putrefactive inflammation in the wound, and the necessity for ulceration of all the coats of the vessel before it can be removed, thus increasing the risk of secondary haemorrhage, and preventing the wound being treated by antiseptic measures. Again, I believe that with the catgut ligature we may yet be able to tie the vessel sufficiently tight to arrest the circulation, without dividing any of the coats, so that should the ligature become slack, or even absorbed, there need be no risk of hemorrhage, or, what is more likely, the formation of aneurism at the seat of ligature. I am of opinion that the catgut ligature is truly reliable if properly prepared, and the wound kept perfectly aseptic, and that the cause of failure in the hands of many surgeons, has been the neglect of this precaution. In my own experience of wounds where the vessels have been tied with catgut, I have found the knot present several days after being applied, when I had treated antiseptically; but in other cases, when I used water-dressing, no trace of ligature could be found after the second day, and before that it had begun to soften. This I attributed to the acrid properties of putrefactive pus, and not to the hygrometric properties of the ligature.

Dr. G. Y. Heath (Lancet, March 17th, 1877) records a case of successful ligature of the subclavian artery with a catgut ligature, the wound being dressed with gauze, after Mr. Lister’s method. In the transactions of the Clinical Society (Lancet, March 3rd, 1877), Mr. A. T. Norton records a case of ligature of the femoral, after this manner successful, so far as the operation was concerned, but the patient died twelve days afterwards from embolism of the basilar artery. On examination of the vessel after death, no trace of knot or ligature could be found, the middle and inner coats were divided, the sac contracted and filled with clot.

The use of Esmarch’s bandage in the treatment of popliteal aneurisms has lately been practised in England, and notes of several cases having appeared in the medical journals by Dr. Reed, Mr. Wagstaffe, Dr. T. Smith, and others. I gave the method a trial in my second and third cases, carrying out the details as described by Dr. Smith as well as possible. In the first case the experiment failed. I kept the bandage on for an hour, followed by alternate digital and mechanical pressure for eleven hours, my assistants not being sufficient to keep up digital pressure the whole time. On removing the bandage, the tumour was decidedly harder, but softened again in a few hours, so that at the end of twelve hours’ treatment it was quite soft. Feeling sure that the want of success was due to imperfect application of the pressure, I tried it again a few days afterwards. I kept the bandage on one hour and twenty minutes, and afterwards watched the case closely as to the pressure after removal of the bandage, but was again unsuccessful. The manner of applying
the bandage is described in the notes of the case. On account of
the second failure, I ligatured the vessel a few days afterwards with
catgut, and he made a good recovery.

During the time he was under treatment, another case came into
hospital, and I tried the bandage on him; and although the process
was carried out in a manner exactly similar to the former case, a
perfect cure resulted.

In the former case something was wanting to secure success, and
what that something was is a matter of interest. The tourniquet
used was the same, the same person carried out the digital pressure;
the time the bandage was kept on was less in the successful case
than in the other. In the former case there was evidence of
thickening of the sac, and of deposit on its walls which should have
favoured coagulation. In the latter the walls were very thin and
the sac easily emptied, showing there was no roughness of the
contents to induce coagulation.

This patient had been treated for aneurism of the other leg
eleven years ago by Mr. Fitzgerald, who only employed digital
pressure.

This method of treating aneurism, appears to me to possess the
advantage of completely arresting the circulation in the limb, and
thus the blood contained in the aneurismal sac is brought to a state
of complete stagnation, undisturbed even by the minute current
from the collateral circulation, a condition most favourable for
coagulation, and thus a clot is formed which, though soft, will soon
become hard if protected by complete pressure on the vessel
afterwards.

The great object in this treatment, therefore, is to watch jealously
the compression, so that not one jet of blood can pass through the
artery against the clot during the process of condensation, and I am
induced to think that in my first case, the parties entrusted with
this duty failed to carry it out effectually.

In the second case, no doubt, having profited by the experience of
the first, all the details were more strictly attended to, and to this
only do I attribute the success. I have no doubt that further
experience of this mode of treatment will prove it to be a great
advancement in this branch of surgery. It has the advantage of
doing no harm, and does not complicate the case or in any way
interfere with other treatment being afterwards carried out, and is
in itself simple and easy of application, and well worthy of the
attention of the profession.

CASE I.

James J., mt. 45, a wood-carter, admitted on September 19th,
1876. History:—Patient states that about six weeks before
admission he suffered from a numbness and constant aching pain in
the left leg and foot below the knee, which rendered him lame.
He thought it was rheumatism, and took little notice of it until a
fortnight before applying for relief, when he noticed a swelling
behind the knee-joint about the size of a walnut, which gradually
increased in size and began to beat very much; the pain also increased up to the time of his admission into hospital.

He cannot attribute this state to any definite cause; the tumour came on gradually.

He had syphilis about fifteen years ago, and he was a patient in this Hospital for three weeks in 1874, suffering from severe cephalalgia, which was treated as syphilitic meningitis. He has attended the hospital as an outdoor patient at short intervals ever since that time.

On admission, patient, a strong healthy-looking man, of a florid complexion, complained of a pain in the left leg below the knee, with numbness of the foot. There was a pulsatory swelling in the popliteal space about the size of a goose's egg, the pulsation expansile on all sides, and the tumour could be dispersed by pressure. Compression of the femoral artery stopped the pulsation and reduced the swelling considerably. All the veins of the leg were distended, as if from pressure of the tumour on the popliteal veins. The arteries at both wrists were slightly tortuous, and the pulse hard and jerky. The pulse in the posterior tibial of the affected side at the ankle, was a little behind that of the right, and softer.

His general health was very good, and he had very little pain in his head.

As it was evidently a case of aneurism of the popliteal artery, he was kept in bed for a week, with the knee firmly flexed on the thigh. On the 26th, as there was no change in the condition of the tumour, alternate digital and mechanical pressure was applied to the femoral for thirteen hours, and although the swelling appeared a little harder, no permanent benefit was produced, so it was decided to ligature the femoral in Scarpa's triangle, which I did on October 16th.

The operation was performed under a spray of carbolic lotion, 1 to 40; no difficulty was found in securing the vessel. I tied the vessel with a catgut ligature prepared by myself, and the ends were cut off short, the wound closed with catgut sutures similarly prepared, and dressed with carbolic oil, 1 to 10. He made a speedy recovery; the wound healed, by first intention, without suppuration; the tumour gradually disappeared until it was only the size of a large marble. He was discharged on Nov. 21st, five weeks after the operation, and returned to his work as a wood-carter, which arduous occupation he has followed ever since, without any return of the aneurism.

CASE II.

John M'H., wt. 50, labourer, admitted July 13th, 1877. History:—Patient made the following statement: That a week before admission, while out working, he felt his right leg become cold and numb, with pain at the back of the knee, so that he could scarcely bend it, and he had great difficulty in walking home. On arriving home, he first noticed a lump behind the knee, which he is
positive was not there in the morning. He did not receive any injury to the part, and cannot account for the presence of the tumour. He has always been a healthy man; never had syphilis; family history good.

Patient is a strong, healthy-looking man, of medium height and sanguine temperament.

There was a pulsating, expansile tumour, about the size of medium-sized orange, in the right popliteal space; the tumour equally expansile, the pulsation strong, bounding; pressure on the tumour dispersed it; compression of the femoral artery stopped the pulsation and caused the swelling to be reduced. As it was evidently a case of popliteal aneurism, rest in bed was first tried. A large abscess formed on the thigh of the affected leg two days after admission, which prevented any treatment being tried.

On July 27th, the abscess having healed, flexion of the leg on the thigh was tried until August 2nd, and though the tumour was somewhat lessened, no permanent good was effected. A conical bag, containing 4lbs. of shot, was then placed over the femoral artery, the point of the cone only pressing on the vessel, the bag being prevented from falling over by being slung into a wire cage placed over the leg. This treatment was adopted to gradually slow the current, and to promote the establishment of the collateral circulation prior to other remedies being tried. On August 11th the shot was increased to 5lb. This caused considerable pain along the course of the vessel, and the patient could not bear it beyond the 13th.

On August 16th I determined to try the effect of applying Esmarch's bandage, after the manner described by Dr. T. Smith in the *Lancet*, May 26th, 1877. The bandage was applied firmly from the foot to the lower margin of the swelling; the patient was then made to stand up to allow the aneurism to fill completely, and then the bandage applied above the swelling (not over it) and the elastic tubing firmly applied over the middle of the thigh. This completely arrested all pulsation.

Ten minutes after application of the bandage, the pain became so severe that I injected half a grain of muriate of morphia under the skin, which relieved it for a time. The bandage was kept on for exactly an hour; during the last ten minutes the pain was excruciating, but the patient preferred bearing it rather than take chloroform. A Carle’s tourniquet was applied over the femoral before the bandage was removed, and kept on for an hour, after which digital pressure was regularly alternated with pressure by the tourniquet, at intervals of an hour each, for the next ten hours, at the end of which time the tumour was considerably harder, but the pulsation was most decided.

Thinking that perhaps the non-success of treatment might be due to some neglect of details, I carefully went over Dr. Smith’s account of his own cases, and on the 24th I again applied the bandage in the same way as before, and kept it on for one hour and twenty
minutes, and again arrested the blood-flow through the femoral by digital pressure and tourniquet for twelve hours. The change in the condition of the tumour was more marked this time, but yet the desired result was not obtained. I kept on the shot-bag until Sept. 6th, when, assisted by the honorary staff, I tied the femoral artery with a catgut ligature, the operation performed under carbolic spray as in the former case. There was a considerable reduction in the temperature of the leg after the operation, and I was under some apprehension lest the ligature might give way, under the constant vomiting which set in and continued for three days.

The wound healed up by first intention, with the exception of a small sinus which evidently led down to the ligature, but there was no decomposing pus and no irritation.

He was allowed up on Sept. 24th, and continued to walk about until October 13th, when a very slight bleeding took place from the wound, due to the granulations of the sinus being irritated by a probe.

He was discharged quite well on Oct. 25th, a small lump about the size of a cherry being all that could be felt of the aneurism.

**Case III.**

The notes of this case were taken by Dr. A. C. Hutchings, Assistant-surgeon.

George R., æt. 39, a miller, was admitted on October 5th, 1877. For some weeks previous to admission, patient had felt numbness and weakness of the left leg and foot, but attributed it to rheumatism. These feelings came on gradually so that he cannot fix any time for their commencement, and they did not appear after any strain or violent exertion that he can remember. About four days before admission, he first observed a tumour behind his left knee, which pulsated violently. He at once consulted his medical attendant, who advised him to come to hospital. No history of syphilis can be obtained, and his general health has always been good.

Present condition: A strong, healthy-looking man, well-nourished. There is a tumour in the left popliteal space as large as a small orange, which pulsates strongly, the pulsation expansile, which ceases at once when the femoral artery is compressed, and the tumour diminishes so much as to be scarcely perceptible; the walls of the sac are evidently comparatively thin, and there appears to be little of that thickening of the coats of the aneurism, usual when the affection has existed so long. All the other arteries appear healthy.

He was kept in bed with a bag of shot, 5lbs. weight, applied to the femoral artery day and night. The patient appeared anxious to avoid an operation, if possible, and paid great attention to the weight.

Four days after admission, as there was no change, Esmarch’s bandage was applied in a manner similar to the previous case, at
12.30 p.m. the pain very soon became severe, and at 12.45 I injected \( \frac{1}{3} \) of a grain of morphia, but the pain increased so as to be unbearable. The patient was then put under the influence of chloroform, and kept slightly affected by it, sufficient to allay the pain until 1.32, when a Carle's tourniquet was applied to the femoral and the bandage removed.

The tumour then felt firm and almost solid: alternate digital and mechanical pressure was kept up at intervals of an hour until 12.50 a.m. next day, when the tumour was quite solid, and not a trace of pulsation could be felt. When the pressure had been applied only four hours, only the smallest trace of pulsation could be felt.

The tourniquet was kept on during the remainder of the night very lightly applied, and the limb rolled in flannel bandages; hot bottles were placed alongside of the limb.

The next day all trace of pulsation gone and the tumour hard; all pressure removed. Leg and foot were warm, and he had no pain, nor was there any swelling.

On the 12th, three days after the bandage was used, the limb carefully examined, but no pulsation could be felt, either in the aneurism or in the anterior or posterior tibials of the affected leg. The vessels of the other leg were also examined, and here a fact which had been overlooked on his admission was discovered: there was no pulsation in the tibials of the other leg nor in the popliteal artery. This appeared strange, and I commented on the fact at the time to the assistant-surgeon and the students. Shortly after leaving the ward, I received a note from the patient, stating that he had suffered from aneurism in the other leg eleven years before, and was successfully treated for it by Mr. Fitzgerald and Dr. Bowen by pressure on the femoral artery. This statement he had before withheld.

October 27th. No return of the pulsation; the swelling much less and harder; no pain in the leg; several vessels can be felt pulsating round the knee-joint. Patient allowed to get up and walk about.

Up to the present time he has progressed well, and feels very little inconvenience from the operation, beyond a little aching when he walks far.

Mr. Gillbee had found most popliteal aneurisms to do well. Generally he had tied the femoral artery, but he had also found other modes successful. It was worth while trying other methods, such as flexion, digital pressure, or Carle's tourniquet, before resorting to the ligature. Tying the artery and cutting off the ends was the preferable mode, but good union was effected also when the ends were allowed to hang out. He had operated with the carbolic acid spray, but he had not found it of much value.

Dr. Reid referred to several cases he had treated, an account of which had been published, and he presented to the Society a monograph detailing some of these.
The next paper read was:

NOTES OF A CASE IN WHICH A REMARKABLE FOREIGN BODY WAS EXTRACTED FROM THE RECTUM.

By RUPERT PINCOTT, M.R.C.S. Eng., GEELONG.

Edward P., ætat. 28, married, uniformly temperate habits, occupation horse-dealer for Indian market, has made seven trips to India. Returned in his usual good health in January last, when he selected land and was occupied in fencing, &c., until April last, when out riding he became much distressed by heat and thirst, and drank freely from a waterhole. To accomplish this he was compelled to lie on his stomach. The water was rather muddy. He did not detect any solid substance enter his mouth whilst drinking. The following day he was attacked with severe gastro-intestinal irritation. A domestic remedy, commonly administered for such attacks, consisting of nearly a teaspoonful of cayenne pepper in a wineglassful of brandy, was taken, which, I need scarcely say, aggravated the symptoms. He came to town, and first consulted me on the 24th April, when he was suffering from acute muco-enteritis. This commenced with gastric irritation and vomiting. The abdominal pain and tenesmus were severe; evacuations very frequent, consisting almost entirely of mucus tinged with blood. After about a week the dejections became muco-puriform, and on May 7th the patient was seen by Dr. Day, who concurred with me that the case presented abnormal symptoms, and suggested that poisonous matter might have been intermixed with the food; but the patient had no suspicion of such an attempt having been made. The case gradually merged into a chronic form of ulceration of the lining membrane of the intestines, with occasional exacerbations of an acute character, which would always be associated with severe bilious vomiting and constipation. The symptoms gradually subsided, but were never entirely absent. In August last he went to the country for change. His diet was of the blandest kind, chiefly milk and farinaceous food. The abdomen was supported by a flannel roller, and the recumbent position enjoined as much as possible. Early in September he returned to town, in consequence of the symptoms becoming more acute in character. He has never been entirely free from pain, and the evacuations have been more or less intermixed with blood and pus. Rest and treatment subdued these symptoms, and at his own request he returned again to the country, promising to conform to my instructions implicitly as to diet and rest. On 6th October he again returned to town. Complained of frequent tenesmus, and was annoyed by a protrusion of the mucous membrane of the rectum. In consequence of some urgent business he went to Melbourne on the 7th, without my sanction or knowledge. Whilst there he was attacked with acute enteritis, and with great difficulty managed to return home on the 9th, when his condition appeared to be very desperate. His features wore the cadaverous expression so pathognomonic of abdominal inflammation. The pulse,
October 28th.—I examined the patient per rectum, passed my finger as far as I could reach in the direction of the left iliac fossa. Detected much thickening from inflammatory deposit, and on exploring very cautiously, the tip of my finger impinged upon a substance which seemed to be a fish bone, but its unyielding nature did not confirm this. By gradually insinuating the point of the finger it passed above the substance, which was lying across the upper part of the rectum. I gradually dilated the sphincter ani, and succeeded, after no little trouble, in extracting from the bowel, by means of my fingers, a foreign body which astonished my patient no less than myself. This was an instrument used for tattooing, consisting of two needles three inches in length (within a fraction—\( \frac{1}{8} \)), which were thrust through a small phial cork, crossing each other in the substance of the cork, and the points extending about a quarter of an inch beyond it. Unfortunately, one of the points was broken off by my finger nail during my attempt to extract it.

The patient was almost frantic with delight at the removal of this “infernal machine,” as he not inappropriately termed it, from his body. His sufferings have been so intense during his prolonged illness, as frequently to induce him to request that I would terminate them by an overdose of morphia. The treatment throughout has been of a strictly palliative character. Purging and rough manipulation avoided most carefully. Opium has been the sheet-anchor, of which enormous doses have been taken to procure anything like freedom from pain. Latterly the hypodermic injection of morphia has afforded him the most relief, and as much as 30 minims of the solution have been injected daily, representing about two grains and a half of morphia. The magnitude of the dose will be apparent when it is remembered that three minims (equivalent to a quarter of a grain) is stated to be the safe commencing dose. At present the patient is free from the severe lancinating pain, which was so agonizing whilst the needles were in the intestine. He still, however, has much pain and tenderness over the indurated spot. Much blood is passed per rectum, of a very bright arterial colour, which I have no doubt exudes from lacerated blood vessels. The last few days he
Medical Society of Victoria.

has complained of much pain and tenderness over the region of the liver, which is enlarged, and I shall not be surprised if either hepatic abscess or suppurative phlebitis result from the absorption of pus by the portal vein.

I need scarcely say that the passage of foreign bodies “per rectum” is not an uncommon occurrence, and when metallic substances, such as coins, are swallowed, but little anxiety is felt by the physician when consulted for such an accident. The peculiarity of this particular case consists in the unusual nature of the foreign substance, and the mystery with which it is enveloped, inasmuch as the patient declares most positively, and I believe in perfect good faith, that he has no knowledge whatever how the substance could have been introduced into his intestines.

Numerous professional and non-professional friends have examined it, and fail to give any satisfactory explanation. Various suggestions have been offered, for example, that the needles would be floated in a perpendicular position by the cork, and that the patient swallowed them when drinking at the creek; but inasmuch as the points of the needles would be the first to enter the mouth, they would impinge upon the mucous membrane of the fauces and become entangled at the commencement of the act of deglutition; and moreover the patient states that he took care to suck the water through his closed teeth, as is the custom of bush travellers; and besides, his mouth was protected by a long moustache. Then it has been suggested that the needles were enclosed in food and thus swallowed; but assuredly an attempt would be made to masticate such a large mass, and thus they would be detected. It has been hinted that this foreign body might have been swallowed designedly as a means of self-destruction, inasmuch as the patient had insured his life very heavily only a short time before the commencement of his illness, and the insurance agents were on the qui vive. I need scarcely say that no sane man would resort to such a mode of self-destruction, and I am quite convinced that the torture which he endured, would have extorted a confession, the more so as it was more than once hinted that his symptoms indicated a foreign substance passing through his intestines. This would imply suspicion of foul play, so that I am fully satisfied such an explanation may be scouted in toto.

The sensational explanation, if I may so term it (and I think you will agree with me, not inaply), consists in the firm conviction entertained by my patient that he has been “got at,” to use a stable term, and that this instrument of torture has been passed down his throat whilst in a state of insensibility; although he confesses that he has no recollection of having been narcotized, but his suspicions have been aroused by the fact that a party of Persians whom he brought out with him on his last trip from India had threatened to murder him. My patient had made arrangements with these men to travel through the colonies and exhibit the Indian game of polo. The speculation eventuated in a complete failure, and he was consequently unable to carry out his agreement with them. Legal proceedings were commenced, and the greatest hostility displayed towards him.
It is well known that the Orientals are adepts at poisoning and secret modes of murder. I am informed by a gentleman familiar with the manners and customs of India, that the Thugs practise a mode of slowly and painfully destroying life by the introduction into the intestines of sharp metallic bodies and pieces of glass intermixed with the food, or during insensibility induced by “bang,” the popular name of Indian Hemp. My patient states that he has seen the Persians, whilst in his employment, tattooing their limbs with instruments exactly similar to that extracted from him.

It has been suggested that the foreign body might have been coated with wax or tallow, formed into a bougie, and introduced per rectum. I cannot accept this explanation, inasmuch as I believe it would be impossible to thrust it so high and place it across the intestine without the patient’s knowledge. Equally difficult is it to imagine that such a body could traverse the extensive track of the intestinal canal. The ileo-caecal valve would seem to present an almost impassable barrier. Assuredly it must be confessed that the case furnishes an additional illustration of the amazing conservative powers of nature.

I regret that I am compelled to conclude my remarks with the same query with which I commenced—How did this foreign substance become introduced into the body? and I trust that this meeting may be enabled to solve the mystery.

Mr. Gillbee was of opinion that the foreign body had been pushed up the rectum. It would not be difficult to do so by means of a hollow tube. He could not believe that it had passed down through the alimentary canal. It had not the look, moreover, as if it had been subjected to the action of the gastric juice.

Dr. Williams also thought it had been introduced per anum.

Dr. Hinchcliffe referred to a somewhat similar case of a carpenter, who had pushed up a plug of wood, having in it a large nail.

Dr. Neild, to show what a large quantity of foreign bodies may be passed down into the bowels, referred to an exhibit of Mr. Ford’s some time ago. This consisted of a double handful of nails, screws, pieces of iron, glass, earthenware, and tobacco pipes, of the latter there being one quite whole, five or six inches long. These had passed down to the cæcum, where a small brad having penetrated the bowel, fatal peritonitis had been set up.

Mr. Pincott, in reply, remarked that the mystery was that the patient was ignorant how the thing had got into his inside. The presumption was that these Persians had got at him and given these instruments to him with a murderous intent, for it was most unlikely he would resort to such a horrible mode of suicide. It was possible they had first drugged him with cannabis indica, but there was no evidence in proof of this. That the instrument was introduced by the mouth was probable, from the fact that the pain and distress first commenced in the region of the stomach.
NOTE ON THE "BITTERBARK" OF NEW SOUTH WALES AND QUEENSLAND.

By BARON FERD. VON MUELLER, C.M.G., M. & Ph.D., F.R.S.

In various Australian journals, and at different times as well as recently in European papers, attention has been drawn to the "bitterbark" of our eastern colonies as yielding quinine; and even the cultivation of the tree furnishing this bark has of late been recommended in continental journals. To prevent disappointment, I consider it my duty to point out that our so-called bitterbark contains no quinine. This was ascertained more than a dozen years ago, at a time when I had no laboratory at our Botanic Gardens (though certainly mine was pulled down again five years ago), and when I requested my celebrated friend, Dr. Wittstein, of Munich, one of the ablest analytical workers in organic chemistry of this century, to subject the Australian bitterbark to a close investigation. This was done at once with the greatest readiness, under Dr. Wittstein's surveillance, by Dr. Conrad Palm, who published the result of the analysis at the time in a full dissertation. Reference to this investigation took place on the occasions when I sent the bark to the great exhibitions of London and Paris. The result of the Munich analysis is best explained in Dr. Palm's concluding words:—"An indifferent resinous bitter principle (not alkaloid), which approaches caiicdrin and toluccumin; volatile oil of camphoric odour; tannic acid turning green with iron salts, gum, resin, vegetable fat, wax; some protein, oxalic and citric acid."

I must remark that even at a preliminary investigation of my own, I never searched for quinine in this bark, as the tree which furnished it, viz., Alstonia constricta, belongs to Apocynace; and although identical alkaloids, for instance berberin, have been found in orders of plants systematically widely remote, yet phyto-chemic investigations have advanced so far now-a-days as to render the search for quinine (and also the allied alkaloids, cinchonin, quinidin, and cinchomadin) in other plants than those of the genus cinchona almost hopeless.

That the bitter principle, and perhaps some other ingredients, in the bark of Alstonia constricta may serve as a febrifuge, would not be surprising, when one remembers what extensive numbers of plants are drawn into use in various countries as remedies against fevers, particularly intermittents. Moreover, in India the Alstonia scholaris (R.Br.)—the occurrence of which tree also in North Queensland was first demonstrated by me—yields a bark largely in legitimate medical use in India as a tonic. But very recent researches of Hesse and Jobst have also proved, that the dita-bark (that of A. scholaris) does contain a peculiar alkaloid, the ditamin, and a small quantity of this may after all yet be discovered in A. constricta or any other species, several now being known—mainly through my own exertions—from the Australian continent.
Foreign journals went so far as even to recommend the cultivation of the *Alstonia* for quinine, but as this tree could never be compared in any therapeutic point of view to the principal cinchonas, it would be far more advisable to push cinchona-culture anywhere in forest regions free of frosts, except in the hot equinoctial lowlands. That the cinchonas are very amenable to culture, that they are of comparatively quick growth, and that they endure considerable vicissitudes of clime, was demonstrated, even under unfavourable circumstances, at Berwick, where Mr. Robinson brought plants of *Cinchona calisaya*, given by me to that gentleman a few years ago, in the open air to flower, far from forest-land, and in a latitude as far as 35° S. The importance of cinchona-culture in warm, moist, temperate zones may be grasped from the fact, that Dr. King, the Director of the Botanical Gardens of Calcutta, reports the crop of cinchona-bark obtained from the Government plantations of Upper Bengal to have amounted, during last year, to 207,781 lbs. of dry bark (chiefly from *C. succirubra*), not to speak of what is extensively done in the Madras Presidency, Upper Ceylon, Upper Java, either by Government, or by numerous planters on their private estates; and yet this culture originated but comparatively a few years ago in South Asia. Far-seeing statesmanship and enlightened journalism should foster this culture also in Australia and elsewhere. In conclusion, I may remark that nothing is further from me, than to discourage the use of alstonia bark, or any other of our native vegetable products, or the educts therefrom. Contrarily, I may fairly claim that I have urged for many years (alas, often unsuccessfully) the fullest development and cognizance of our native vegetable resources; and recently, even under adversities, which long and largely impeded my professional work, I managed to issue, at my private expense, a translation, augmented by many additional notes, of Wittstein's "Chemistry of Plants," by which means medical and chemical gentlemen in the Australian colonies will have additional facilities to extend the domain of our therapeutic and industrial knowledge, also as regards our native vegetation, by independent local researches.

A CASE ILLUSTRATING THE USE OF THE TROCAR AND CANULA IN ANASARCA.

By GEORGE HALEY, M.B., Wangaratta.

Peter O. suffered from anasarca, the result of organic visceral disease. The whole body was affected, the legs being of an enormous size. Latterly, on account of their weight (together with debility), he had been quite unable to move them. As he was very anxious to get rid of this burden to his limbs, I determined to try and draw off the fluid by means of a small trocar and canula (one belonging to my pocket-case). With this view I passed the
instrument through the skin of the leg, just below the calf, into the subcutaneous tissue. Immediately the trocar was withdrawn the water began to flow, and continued to do so until the canula was removed. About four pints came away in four hours. After the canula was removed I sealed the hole in the skin with collodion. On the following day a similar quantity was drawn off, by passing the canula into the same opening. On the third day the other leg was treated in the same manner; and, after a few days' treatment, intervals of rest being allowed, the oedema had almost completely disappeared, and the patient could move out of his bed. To carry off the fluid, indiarubber tubing was attached to the canula. The advantage of this mode of treatment over that of making incisions, &c., will at once be seen; also its superiority to that of using diuretics, which so frequently fail, besides upsetting the digestive organs. I may state that I found this mode of treatment speedy, clean, almost painless, and, last but not least, it may be discontinued at will. It will be hardly necessary to say that the patient required supporting medicines and diet.

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NOVEMBER, 1877.

CONSULTATIONS.

Looked at from a common-sense point of view, there should be no difficulty about consultations. The interest of the patient should be the principal object in the mind of the medical attendant, and as nobody ought to be above listening to advice, there can surely be no harm in one medical man taking counsel with some other medical man, upon any given case. No doubt, in many consultations, there is no difficulty, and there arises no sort of unpleasantness in any way. But it is equally true, that in others there is much difficulty and a great deal of unpleasantness. Some medical men always regard it as an evidence of lack of confidence when a consultation is proposed, and resent the suggestion accordingly. Others are rather in the habit of anticipating the proposal. No doubt circumstances a good deal determine the course to be adopted. Thus, it cannot be denied that the profession is somewhat broken up into sections. Ill-conditioned people call them cliques. Now, in any particular circle the members make a practice of calling each other in, and they do not like to go out of the circle. In fact, in some circles it is next to impossible to
effect a consultation, other than between those who compose it. Perhaps this system has its advantages. Three or four men devote themselves to a particular branch of medicine, and it is only in reason to suppose, that they have an advantage over those who do not limit their observations to one organ. This, however, is not always the motive which keeps together the members of a consultation section. It is certainly pleasanter to meet a man whom one knows and understands, than a comparative stranger. Thus, then, this system of consultation-partnerships is not without its recommendation. It is certainly impossible for any medical man to be so completely free from antagonisms, as to be able to meet any or every other medical man in a friendly fashion. There always have been, and there always will be, antagonisms in the profession. And yet we are sometimes confronted with this alternative: either we must meet a man to whom we entertain the very strongest objection, or we must lose our patient. And to give up a patient under these circumstances, is very often to suffer most unmerited wrong in consequence of a subsequent unscrupulous disparagement. It is not the rule for one medical man to disparage another, when he is placed in charge of a case which has just been under treatment by some-one else. But it is by no means the rare exception.

And even when the patient is not surrendered, an irreparable wrong is sometimes done, and that not always intentionally, by the consultant. It is, to be sure, absurd to suppose that a consultant is called in simply to approve of what is being done, and to make no change in the treatment, for fear it should seem as if he passed a censure upon the gentleman he is called to meet. At the same time, when a change is made, the manner of suggesting it is not seldom calculated to do mischief to the ordinary attendant. It is not every man who is possessed of tact, or taste, or diplomatic skill, sufficient to explain to a patient, or his friends, that it has been deemed desirable to make some modification in the treatment; and in the case of an old practitioner meeting a much younger one, the absence of tact may be tantamount to the ruin of the reputation of the latter. It is quite possible, even when an error has been committed, to keep the knowledge of it from the friends of the patient, and save in very rare instances indeed, is it not a duty to withhold such a disclosure? But such reticence is not universal. Indeed, we have all examples in our recollection, where a consultant has taken secret means to inform the patient or his friends, that he has been wrongly treated, and the patient
Consultations.

has, in consequence, been lost. It need hardly be said that there is only one word suitable for denouncing conduct of this kind. But such conduct has happened, and does happen, and probably always will happen for a long time to come, and until the professional millennium shall arrive. But it sometimes comes about, without any underhand dealing at all, that patients are so agreeably impressed with the manner, or with the results of the treatment of the consultant, that they prefer to retain him and to dismiss the other. In such a case the one who is so preferred, is placed in a somewhat embarrassing position. If he refuse to attend, he probably loses a patient, and does his friend no service, for the patient generally, under the circumstances, will then select a third medical man. It can hardly be questioned that it is the duty of the second attendant to endeavour to persuade the patient to retain his first attendant, and it is equally his clear duty to make the first attendant aware of the desire of the patient. Most men will relinquish a patient when some other medical man is thus preferred, and then there can be no objection to the second medical man taking him. But it is an unpleasant position in which to be thus placed, and it frequently leads to bad feeling and permanent professional estrangement. It is always desirable in a consultation, to have a private conference out of the presence of the patient before the examination is made. For every man has his own manner of making an examination, and if the consultant should go through a number of showy forms, and ask a great number of irrelevant, but to the patient seemingly important, questions, it is most likely that the patient will come to the conclusion that he has been neglected, and has not had his proper share of attention. An honourable man will endeavour to make his own method conform as nearly as possible to that of his associate, and will not endeavour to gain an unfair advantage, by seeming to possess a superior measure of knowledge. For during most kinds of sickness, every man’s apprehension is greatly quickened, and his habit of observation, so far as he himself is concerned, is strengthened. Perhaps it is right to say that, as between a man in health and a man who is a patient, there is a larger infusion of selfishness in the moral nature of the latter, and therefore that he will be very likely to prefer that attendant who devotes the largest measure of time to him. On the other hand, it would be unreasonable to prohibit the consultant from adopting every means to make himself thoroughly seized of the condition of the patient. There are some men
whose instincts will always guide them rightly in these matters. There are others who, although well-meaning, invariably blunder. Altogether, the question of consultations is surrounded with difficulties. It would be hard to frame rules for guidance in consultations, and yet it is certain there are well-understood rules which ought not to be departed from. It is more than a matter of taste, although taste, as an element, enters largely into the determination of the form and the manner of these conferences. It is a question of honour, of feeling, of consideration. And yet, if a sacrifice is to be made, it must not be all on one side. It is often a matter of concession. If all men were alike intelligent, thoughtful, and high-minded, there would be no difficulty. But all men are not so, and thus there come complications and embarrassments which no one can foresee.

REGULATIONS FOR THE POISONS ACT OF 1876.

Whereas by the 12th section of The Sale and Use of Poisons Act 1876, the Governor in Council may, on the recommendation of the Pharmacy Board of Victoria, from time to time, make any regulations as to the sale or custody of poisons or otherwise as to carrying into effect the objects of the said Act; and whereas the said Pharmacy Board of Victoria have recommended to the Governor in Council that the provisions hereinafter mentioned should be made for the purpose of more effectually carrying into effect the objects of the said Act: Now therefore His Excellency the Governor of Victoria, with the advice of the Executive Council thereof, doth by this present Order make the following regulations, that is to say:

DEALER IN POISONS.

1. Any person not being a legally qualified medical practitioner or a registered pharmaceutical chemist of Victoria, who desires to obtain a certificate to sell poisons under the provisions of the said Act, shall make an application to the Pharmacy Board of Victoria in the form or to the effect in the First Schedule hereto, and shall furnish and forward to the board the information and certificates therein mentioned.

2. The board upon receipt of such application may grant to the person therein named, if it thinks fit so to do, a certificate in the form prescribed in the Second Schedule hereto upon payment to the registrar of the board of a fee of Twenty shillings per annum, or a proportionate part for any period less than a year.

3. Such certificate shall continue in force until the 31st day of December next ensuing the date thereof, and thenceforward upon
Regulations for the Poisons Act. [Nov.

payment to the Registrar of the board for each and every year a fee of Twenty shillings, unless and until such certificate shall have been cancelled by an Order of the Governor in Council made in that behalf.

4. The Registrar, upon payment to him of such fees, shall give a printed receipt for each and every fee, and also endorse on the back of such certificate the date of payment and the period for which such fee is paid.

SALE AND CUSTODY OF POISONS.

5. The holder of a certificate to sell Poisons shall keep a book in the form prescribed by the Second Schedule to the Sale and Use of Poisons Act 1876, and make such entries therein and take such steps in selling poisons as are required and directed by the provisions of the said Act. The book shall be open for the inspection at any time of the police or of any person authorized by the Board in that behalf.

6. Every holder of a certificate as a dealer in poisons shall provide a cupboard, substantially made, fastened, and secured with a sufficient lock and key. Such cupboard shall be of not less dimensions than two feet six inches wide, one foot six inches deep, and three feet high, and shall be fitted inside with sufficient shelves and divisions to keep each description of poison therein contained in a separate division; and such cupboard shall have the word "Poison" conspicuously painted or written thereon.

7. Every holder of a certificate shall keep the key of such cupboard in his possession; he shall not permit such cupboard to remain open or unlocked, or to be opened by any person except himself; nor shall he authorize or permit any person to handle or sell for him the poisons therein contained; he shall not delegate or entrust any duty, task, or obligation imposed by the said Act in connexion with the custody and sale of poisons to any other person under any pretence whatever, but shall perform such duty, task, or obligation himself.

8. In the event of the holder of a certificate becoming incapacitated by absence or illness from attending to the sale of poisons, the Board may authorize some fit and proper person to act as a substitute for such holder of a certificate under such circumstances, and such substitute shall for all purposes in connexion with the sale and custody of poison be deemed to be the holder of a certificate, and be personally responsible whilst he is so acting.

FIRST SCHEDULE.

APPLICATION FOR A CERTIFICATE TO SELL POISONS.

To the Pharmacy Board of Victoria.

Gentlemen,—I have the honor to apply for a certificate under the authority of the Act No. 559, to enable me to sell poisons. I
reside at , distant at least four miles from any city, town, or borough, and in which place there is not a registered pharmaceutical chemist keeping an open shop.

My premises contain rooms, and I have affixed in one of the said rooms a cupboard of the dimensions and with the shelving required by the said Act, and the regulations made thereunder. I forward herewith a certificate, in the form provided, from a legally qualified medical practitioner, and also a similar certificate from a police magistrate, which certify that I am a person of sober habits and of good repute, and a fit and proper person to be allowed to sell poisons in the said place.

I have the honor to be, Gentlemen,

Your most obedient servant,

SECOND SCHEDULE.

Sale and Use of Poisons Act, No. 559, 1876.

PHARMACY BOARD OF VICTORIA.

The Board has granted to residing at a certificate as a dealer in poison, subject to the provisions of the Act and the regulations made thereunder.

Dated at Melbourne, this day of 18

Registrar

FORM OF CERTIFICATE.

This is to certify that I know A. B., of who is an applicant for a certificate to sell poisons, to be a person of sober habits and of good repute, and a fit and proper person to be allowed to sell poisons under the Sale and Use of Poisons Act 1876.

(Signed) E. F.,

Legally-qualified Medical Practitioner.

[Similar Form of Certificate.]

(Signed) G. H.,

Police Magistrate.
OCTOBER TERM 1877.

ORDINARY EXAMINATIONS IN MEDICINE.


SPECIAL SUBJECTS.

SURGERY: E. G. Ochiltree.

GENERAL ANATOMY, PHYSIOLOGY, AND PATHOLOGY: E. G. Ochiltree.

PRACTICAL CHEMISTRY: F. L. Curtayne.

HONOUR EXAMINATION.


SPECIAL PRIZES GIVEN BY DR. KIRKLAND.


DEGREES CONFERRED.

At a meeting of the Council held on November 17th for the purpose of conferring degrees, the following were conferred:

BACHELOR OF MEDICINE.

**GRANTS FOR HOSPITALS FOR 1877-8.**

The following schedule shows the distribution of the grant-in-aid of the hospitals for this colony, for 1877-8.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Maintenance</th>
<th>Building or other special purpose</th>
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MELBOURNE HOSPITAL CHRONICLES.

November 20.—Committee Meeting: Resolved, "That no further cases of scarlet fever be admitted from the Industrial Schools. Resolved, "That any paid officer or servant of the hospital who canvasses or influences, or causes to be influenced, the voting of any subscriber at any annual or other election, either in favour of or against any person who is a candidate, shall, on proof thereof, be dismissed and be held to be ineligible for future employment by the corporation.

CORRESPONDENCE.

NOVEL THERAPEUTICS.

To the Editor of the Australian Medical Journal.

Rochester, November 16, 1877.

Sir,—I enclose you a copy of a prescription brought to me to dispense. The original I have in my possession. If you think it worthy of a place in your work as a specimen of the enlightened style of prescribing in the nineteenth century, I would ask your readers if they would own such a man as a brother, or if he is not more fit for treatment in another way.

I remain, Sir, yours, &c.,

PHARMACEUTICAL CHEMIST.

"To heat a hammer in hot water, or heat a smoothing-iron, and iron the thigh.

"Get a box of Kram's pills at Laly's store, and take one twice a day.

"x. x. xxxxxx."

REVIEW.

Notes on Consumption and Wasting Diseases successfully treated with Hydrated Oil. By G. Overend Drewry, M.D. London, 1877.

Dr. Drewry bases his belief in the utility of this mode of treatment upon what he regards as the recognised fact that in wasting diseases, the patient makes rapid improvement when an increase in weight begins to show itself, and that therefore the
mischief caused by ulceration, and suppuration in the lungs, can be repaired, if the general nutrition of the body can be maintained. He says:

"The whole matter hinges upon the transformation of fat in the body. It has been believed, up to the present time, that the fatty matters of food are reduced by the juices of the body in health to the form of an emulsion, and absorbed through the membrane of the lacteals in that condition, and it is believed to be impossible to produce a true solution of oil in water. That these views are not correct I shall be able to prove.

"In the experiments to which I have alluded, which were made principally on large dogs, the animals were fasted for forty-eight hours, a meal of fat was then given, to which was added some leather, cut into pieces, to excite activity of digestion; and different periods allowed for this process to be performed. The animals were then killed, and stomach, duodenum, pancreas, &c., immediately removed and examined.

"In all these instances oil was found in true solution—that is, capable of being taken up both by water and alcohol, without producing the milky appearance characteristic of an emulsion. It was also found to exist in this condition in the pancreas as well as in the duodenum.

"Further experiments showed that, in addition to oil in solution, it was present also in the form of emulsion; and that there was also a certain amount of soap, which it is held to be impossible to make artificially in the ordinary way, at a lower temperature than 176° Fahrenheit.

"Proceeding with experiments to produce a mixture which should comply with all these conditions, it was found that pure oil is absolutely insoluble in water, and that the addition of alkalies did not convert it into soap, without prolonged boiling and high temperatures. The solution and saponification which occur in the body, are due to the admixture of the secretions of the pancreatic and other intestinal glands, together with certain constituents of the bile; and this occurs at a temperature not exceeding 100° Fahrenheit.

"A series of experiments, to test how far this combination of oil in solution, saponified, and in the form of the most perfect emulsion—could be produced by synthesis, resulted in a very curious demonstration, that in no other sequence of treatment than that of the natural digestion of fats in the human body, can precisely the same conditions of solution, saponification, and emulsion, be produced.

"Without the ferment principle peculiar to the before-mentioned glands, no true solution of oils or fats can be effected at all, unless the fatty acids are separated, and to a certain extent decomposed at high temperatures.

"The glycerides in combination with bases are only instantaneously
formed after the fatty matter has been fermented; consequently, if the glands of the body, through disease or atrophy, do not furnish these ferments in full vigour and sufficient quantity, the mixture, in contradistinction to chemical combination, either remains inert and passes through the bowels in that condition, and cannot therefore be assimilated, or produces that purgative action which is opposed to the assimilation not only of fats, but also of every other food-matter in the bowels.

"By making first a fermentive emulsion, and then bringing into action the principles of the other reagents displayed in a healthy natural digestion of fatty matters, an artificial partly-digested oil is obtained, the smallest leaven of which is sufficient to excite and carry on a full and healthy digestion not only of the untransformed oil with which it is mixed, but also of the fatty matters found in an ordinary mixed diet.

"Subjecting the mixture so prepared to various tests, it was found that phosphatic salts instantly throw the oil which has been rendered soluble out of solution and emulsion; and it becomes visible on the surface as pure oil.

"The deductions which I made from these experiments were:—

"1st. That in consumption, and many other diseases, there does not exist in the patient the power of dissolving a sufficient proportion of fat or oil, and that in this manner all the fatty tissues, including the nervous system, are starved.

"2nd. That when the oil or fat has been dissolved in water, it is thrown down and fixed again as fat in the fatty tissues, on being brought into contact with various salts, and particularly as regards the nervous structures, with phosphatic salts.

"3rd. That the fat maintained or produced in the body, when this process of solution is properly performed, is not due entirely to this cause, except by this process alone can the nerves be nourished through the medium of which all the other processes of life are carried on.

"4th. That in cases where there is not power to transform the fats of ordinary food, from deficiency of secretion, either pancreatic or biliary, there may be and probably is an advantage to be obtained from the use of cod-liver oil or the pancreatic emulsion of cod-liver oil; the one sometimes assisting the biliary secretion, the other undoubtedly aiding the defective secretion of the pancreas. But when the power of digestion of the fatty matters of food is so far wanting as to produce considerable emaciation, and particularly when there is great repugnance to fats and oils of all kinds, which are passed through the body undigested, neither cod-liver oil, nor any other fatty matters, alone or emulsified with pancreatin, are presented to the weakened digestive organs in the soluble form which alone renders them capable of assimilation. Hence the unsatisfactory results which have attended the use of such oils.
Local Topics.

5th. That in cases where there is great emaciation, if oils prepared so as to secure solution, emulsion, and saponification, are given regularly with food, increase of weight will be obtained.

6th. That in cases where phosphorus appears to be lacking in the system, the phosphatic salts to be administered must not be given with the hydrated oils, but in the intervals between meals.

Dr. Drewry submits a number of cases, which appear to prove the correctness of his conclusions, and he expresses a hope that other practitioners will "test the results of treatment with the hydrated oil, as compared with the best cod-liver oil, or any other preparation of oil, in all diseases in which cod-liver oil is prescribed."

Local Topics.

At the meeting of the Medical Board of Victoria, held on the 2nd November, the following names were registered:—Alexander Böttner, Melbourne, M.D. Berlin 1873, L. et L.M.F.P.S.G. 1874, F.R.C.S. Ed. 1874, L. et L.M. 1874, M.R.C.P. Ed. 1875; Edgar Duke, Melbourne, M.R.C.S. Eng. 1876. The following name was erased from the register, J. J. Hallett, deceased. On the 14th, the following were registered:—Robert Colquhoun, South Yarra, L.R.C.P. Ed., L.F.P.S. G. 1867; John Steele Park, Melbourne, L.S.A. Lond. 1859, L.R.C.P. Lond. 1874.

The following health officers have been appointed:—Mr. E. J. Lock, for the shire of Mount Rouse; Mr. E. J. Bennett and Mr. W. H. Syme for the shire of Stawell; Dr. James Cox, for Hobson's Bay (deputy assistant).

The managers of the Alfred Hospital, on 30th September last, appointed a sub-committee to inquire into the subject of paying wards. The report was agreed to by the sub-committee on the 26th ult. It was to the effect that it is desirable to establish a paying ward in connexion with the hospital, that any experiment in the present building will be unadvisable, and that a wing should be erected to accommodate about thirty-two beds; that the patients be recommended by a contributor, and pay in advance three guineas per week for board, residence, medical attendance and nursing, with two guineas additional for a separate room, and for operations according to a scale. The estimate of Mr. C. Webb, the architect, of the cost of erecting such a building was £7000, or for a portion sufficient for thirty-two beds £4000. On the 16th inst it was resolved to adopt the report, with a few verbal alterations, and to call a special meeting of the contributors for the purpose of obtaining their consent to the appropriation of the building fund for the erection of an additional wing to the building; also to ascertain the conditions upon which the land was granted to them in Prahran.

After a long string of the customary puffing advertisements of the "Gum Leaf Eucalypti Essence," in the Koroiit Express of November 15, there is the following testimonial and mayoral attestation of its genuineness: "Important Medical Testimony. Sandhurst, 2nd October,
NOTICES TO CORRESPONDENTS.

Communications have been received from Dr. Haly, Baron von Mueller, Pharmaceutical Chemist, Dr. Jamieson, Dr. Hinchcliff, Mr. Pincott.

The following publications have been received: The Lancet for Aug. 25, Sept. 1, 8, 15; The British Medical Journal for August 25, Sept. 1, 8, 15; The Medical Press and Circular for August 29, Sept. 5, 12; The Student's Journal for September 1, 15; The London Medical Record for September; The New York Medical Record for September 8, 22, 29; The Pacific Medical and Surgical Journal for September; Retarded Dilatation of the Os Uteri in Labour, by Albert H. Smith, M.D.; Government Gazette of Victoria; Parliamentary Papers of Victoria.