NOTES ON THE ANTISEPTIC TREATMENT OF TYPHOID FEVER.

By A. A. Parry, M.B. B.S., F.R.C.S. Eng., L.R.C.P. Lond.

The following are notes of six cases of typhoid fever treated by the antiseptic method, chiefly by the use of chlorine, a mode of treatment which came into use again in England about a year ago, and was reported upon favourably a few months since by Dr. Burney Yeo, of King's College Hospital.

CASE I.

E. S., ill about ten days, flushed face, dry furred tongue, anorexia, diarrhoea for the last five days, dull pain in right iliac fossa, enlarged spleen, few spots; temperature 103.5°, pulse 120.

For the first two days, corresponding to the eleventh and twelfth of the fever, patient was ordered liq. hydrarg. perchlor. 3 ss. and quininae sulph. gr. ij, quartis horis, with little if any effect, temperature rising to 103° and 103.6° during the two following days, diarrhoea being excessive and very fetid.

On the thirteenth day, he was ordered liq. chlori. 3 j alt. horis. On the following day temperature was 103°, and diarrhoea less in amount. Next day, temperature 102.6°, still less diarrhoea, no fæctor. Next day, no diarrhoea, temperature 101.2°; and next day, temperature having fallen to 100.5°, liq. chlori. was stopped and quininae sulph. gr. v, t.d.s. ordered. Temperature remained at 100.6° the following day, then rose for two days to 102° and 102.8°; diarrhoea again appearing and being very fetid, liq. chlori. was again ordered. Two days after temperature was 102°, and from that fell gradually to normal in six more days—101.2°, 100.8°, 100.2°, 99.5°, 98.7°, 98.0°—patient being convalescent about the middle of the fourth week.

The chief features of this case are the inability of hydrarg. perchlor. to lessen the fæctor or amount of diarrhoea; the reduction of both after the administration of liq. chlori. accompanied by a corresponding decrease of temperature; the increase of diarrhoea...
and rise of temperature when liq. chlori. was stopped, and their subsequent reduction when it was again resumed.

**Case II.**

J. G., aged 19, ill about a week; headache, epistaxis, dry furred tongue, constipation, no abdominal pain, slight distension, area of splenic dulness increased; temperature 104°, pulse 116. Ordered calomel gr. iv., followed by liq. hydrarg. perchlor. 3 ss. and quinine sulph. gr. ij.

The following day diarrhoea had begun, temperature 102°; while next day, diarrhoea was profuse, foetid, and typhoid in character; temperature 102·8°, pulse 120. Ordered quinina sulph. gr. x, at night. The following day, temperature being 103°, liq. chlori. was substituted, diarrhoea still profuse. Next day, temperature 103·4°, delirious last night, very weak, scarcely able to take any nourishment; ordered stimulants. Temperature began to fall next day, 102·5°, diarrhoea becoming much less, tongue much cleaner, patient still weak, but more cheerful. For the next three days temperature fell — 102·2°, 102·2°, 100·6°—then rose to 101·2°; but gradually fell to normal—100·4°, 100·4°, 99·0°, 99·4°, 99°, 98·2°, 98·6°, 98·2°—liq. chlori. being still used, though in less frequent doses.

In this case again hydrarg. perchlor. appeared inefficacious, and liq. chlori. successful in causing the diarrhoea to become less in amount and fetor, accompanied by a lower temperature, the effects not becoming marked until the second day after chlorine had been given.

**Case III.**

Ill eleven days, headache, pain in right iliac region, characteristic diarrhoea, delirious last night; temperature 104·2°, pulse 126.

Though this was evidently a bad case from the beginning, as in the two previous cases, liq. hydrarg. perchlor. and quinine were given, but during the next two days, although the wet pack had been used at night, temperature was 104·4° and 104·8°; and diarrhoea was profuse although pulv. doveri gr. xij had been given several times. Liq. chlori. was ordered in 3 j doses every hour for twelve hours, then every second hour, the wet pack used again at night, but though there was a marked change in the stools the following day, still temperature was 104·4°. Next day the temperature fell to 103·6°, and spots came out in groups all over chest and abdomen, diarrhoea much the same as on the previous
day. For the next four days temperature varied with a tendency to fall—103°, 103·2°, 102·2°, 102·4°; then came a sudden fall to 99·6° with patient partially collapsed and haemorrhage was suspected. Pulv. doveri gr. x and bismuth. carb. gr. viij ordered. Next day diarrhoea, which had almost ceased, began again, dark in colour; temperature rose to 101·4°, pulse 110 soft, compressible; and next day 102·2°. As patient had rallied well, liq. chlori. was again resumed. The temperature rose next day to 103·6°, quinine sulph. gr. ij was added, still the temperature rose to 104·2°. Wet pack was again used. From that time temperature fell—102·8°, 102·4°, 102°—then rose to 103·2°, probably owing to the appearance of a bed sore near one trochanter, corresponding to the healing of which temperature fell rapidly to normal in seven days—102·6°, 101·2°, 100·8°, 100°, 99·6°, 98·8°, 98·6°.

In this case, neither liq. hydrarg. perchlor., nor liq. chlori. seemed of much use at first, and quinine and the wet pack had to be used to reduce temperature. During the later stages, however, liq. chlori. appeared to have the same action on the stools as in the previous cases, and a corresponding fall of temperature resulted, interrupted by the effects of a bed sore.

CASE IV.

A. C., aged 21, complained of slight shivering six days ago, followed by malaise gradually increasing, anorexia, occasional vomiting, diarrhoea, increased splenic dulness, no spots; pulse 120, temperature 101·5°.

This case occurred at the same time as Case III, and was treated in the old method, hst. quinines, t.d.s.; but the effect was certainly not to reduce temperature, for it rose daily—102°, 102·6°, 102·6°—quinine gr. x having been given the evening previous to the last temperature recorded, diarrhoea being moderate in frequency. As hst. quinine had no appreciable effect, it was changed for salol gr. v, sextis horis; temperature that day being 103°. Next day temperature was 101·6°, with no alteration in stools; but the following day the stools were dark, smelling of carbolic acid, urine also a little darker in colour; and temperature 101·6°. Next day stools very dark, urine greenish, patient very low; delirious; evidently suffering from carbolic acid poisoning; temperature was only 100°. Salol was discontinued and liq. chlori. substituted. For the next two days temperature rose to 102·5°, 102·8°, stools less frequent, lighter in colour, no odour of carbolic acid, urine more
abundant, and patient much better. From that time temperature fell rapidly for six days—102°, 101·4°, 101°, 99·8°, 100°, 99·6°; then a slight rise occurred to 100·4°, the bowels being at the same time confined, and temperature falling to 100° after enema; a few days afterwards it rose to 100·8°, 101·2°, and after similar treatment became normal in five or six days.

In this case, the inefficacy of hst. quinina in reducing temperature was shown, also the occurrence of carbolic acid poisoning after the use of salol. When liq. chlori. was given, temperature rose for two days, but this may perhaps be accounted for by the fact that the temperature had fallen very low during the treatment by salol; it soon began to fall, and patient was convalescent about the end of the fourth week.

**Case V.**

Patient ill about twelve days, temperature 104·6°, pulse 130; delirious, diarrhoea excessive. Ordered antipyrin gr. v, t.d.s., and wet pack.

The following day patient was delirious at times, diarrhoea still bad; temperature 104°, pulse 120. Ordered antipyrin gr. v, bis die, liq. chlori. 3 j hourly, and wet pack. Next day, diarrhoea not so fetid, but still profuse; ordered wet pack, quinine gr. x, and liq. chlori. alt. horis. The next two days temperature was 104° and 103·6°; moist sounds at bases, patient much weaker; ordered sp. ammon. co. and sp. aether to alternate with liq. chlori. Temperature fell rapidly for the next three days—103°, 102·2°, 101·6°—and diarrhoea had almost ceased, so now liq. chlori. was stopped, and liq. hydrarg. perchlor. 3 j, t.d.s. given instead. The temperature rose in two days to 102·2°, 103·4°, with increase of diarrhoea; then fell suddenly to 100·6°, with slight haemorrhage into bowel. This was remedied by astringents, and temperature rose for three days—101·4°, 102·4°, 103·0°, liq. chlori. being given during that time; but now vomiting set in, mustard poultices were applied over stomach and spleen, the latter being much enlarged. Vomiting ceased next day, and temperature fell to 102·5°; five days later it was 100°, and then liq. chlori. was stopped; temperature gradually descended to normal, with the exception of one slight rise due to constipation.

Here, in the early part, the action of liq. chlori. was doubtful owing to hyper-pyrexia, that not being overcome till the wet pack, antipyrin and quinine in full doses had been given; the action of
the liq. chlori. on the stools then became evident, and temperature went down correspondingly.

Case VI.

F. E., aged 24, ill about a week; diarrhoea, furred tongue, slight abdominal distension, no spots; temperature 103.4°; ordered thymol gr. jss., t.d.s. For the next two days temperature kept about the same—103.4° and 103.6°—no change appearing in the diarrhoea, so wet pack ordered, and thymol given 6tis horis. Temperature declined slightly, 102.2°–102.4°, then quinine gr. x given at night, and temperature still further declined to 101.6° and 101.2°; then, as the action of thymol had not been very marked, quinine was substituted, but temperature rose a little for the next few days—101.4°, 101.8°, 101.0°, 101.5°, 101.8°—so thymol was ordered to be given alternately with the quinine, then temperature fell slowly to normal—100.8, 100.4, 100°, 100.4°, 99.6°, 99.2°, 98.4°, 98.2°.

This was evidently a mild case, and thymol, quinine, and a combination of both seemed to have no definite action upon the temperature, nor on the diarrhoea.

The following seem to be the chief points of interest gathered from the foregoing cases:

In the first three cases, hydrarg. perchlor. was administered, as being one of the strongest of bactericides, quinine being added for its antipyretic effect, as well as its supposed action on typhoid germs; but from the results of these cases, it would appear that however powerful perchloride of mercury may be in stopping the growth of bacteriological preparations, it loses its effect when used for that purpose in typhoid fever. In Case V, it was given after the diarrhoea had been rendered less in amount and factor by liq. chlori., but diarrhoea soon set in again, the stools being of a typhoid character, although the dose was double that given in the three first cases. In this case it was followed by slight hemorrhage, as before stated.

In regard to liq. chlori., in all cases where it was given, on the following or next following day an evident change for the better occurred in the stools, these losing their typhoid character and factor, at the same time becoming less frequent. Its effect on temperature was not so marked, for as a rule, no decline took place for at least the second day after it had been given, i.e., a day or more after the change in the stools. The increased
temperature and the diarrhoea are both probably due to the action of the products of the typhoid germs, and liq. chlori. seems to stop their development. In no case did liq. chlori. limit the duration of the case.

In Case IV, where salol was used, no deductions can be drawn for or against its use, as in that particular case, symptoms of carbolic poisoning set in. Similarly Case VI, where thymol was used, was so slight that it would probably have recovered under any rational treatment.

As the typhoid season is now setting in, notes of cases treated by various antiseptic methods will no doubt be acceptable to the profession.

A CASE OF LEPROSY.

By A. W. Finch Noyes, Jun., F.R.C.S. Ed.

Surgeon to the Department for Diseases of the Skin, Melbourne Hospital.

The following case, which occurred amongst my out-patients at the skin department of the Melbourne Hospital, is reported with a twofold object. Firstly, it is instructive as showing the long incubation period of leprosy, and it is interesting as being the only known case of a European suffering with the disease, and this in its earliest stages, in Victoria. Secondly, because it gives me the opportunity of drawing attention to a simple method of diagnosis which is as useful in doubtful cases of tubercular leprosy, as sputum examination is in cases of pulmonary or laryngeal tuberculosis.

The method is as follows:—Clamp a suspected leproma with a pair of Péan’s forceps. When the tubercle thus clamped is quite bloodless, prick the tense skin and collect the exuding serum on a previously sterilised cover glass, pass the glass quickly through a spirit flame, to set the albumen, and put it aside for future staining. The easiest method of staining consists in floating the cover glass on a solution of carbol. fuchsin for ten minutes, decolorize in sulphuric acid, wash in water, and set in xylol, Canada balsam, or glycerine.

By the above method, I was able to demonstrate to those who doubted the diagnosis, the presence of the lepra bacillus, and consequently the existence of leprosy in the patient.

The distinction between the lepra bacillus and the tubercle bacillus, which it closely resembles, is of little practical consequence.
here, as the two conditions are not likely to be confounded in the skin; but it may be mentioned, if any doubt occurs, that the tubercle bacillus, as compared with the lepra bacillus, is smaller, and is less susceptible to aniline stains, and it is possible to make artificial cultures, which have a characteristic growth, with freshly obtained bacilli.

The following are the notes of the case:—

A. F., a well-developed, robust-looking man, aged 35 years, born in India of European parents, both of whom were free from any leprous taint. Till within six years ago, when he arrived in Australia, he had followed the calling of a sailor; since then he has been engaged in various situations, but has never directly or indirectly been brought into contact with leprous subjects. Whilst at sea he traded to South America, Burmah and India. The last case of leprosy that he saw was in Rangoon in 1883. Patient has suffered from the ordinary diseases of a tropical climate—diarrhoea, dysentery, &c.—but otherwise he has enjoyed excellent health. In 1877 he contracted a chancre, which he says was treated as syphilis; he has, however, never suffered from any secondary or tertiary symptoms since. The first signs of the present disease commenced eighteen months ago, that is four and a half years after his arrival in Australia; thus, unless contracted in the colonies, a contingency far from probable, the disease must have had an incubation period of between four and five years. This is not unusually long. Leloir has reported a case with an incubation period of fourteen years; Besnier one with twelve years, and Wolff one with twenty years. Probably, during this period of latency, the bacilli remain inactive at the seat of inoculation. Arning, during his inoculation experiments on the condemned man Keanu, showed that bacilli could be found at the point of inoculation as late as fourteen months after the first inoculation, though the patient had not manifested a single symptom of leprosy. This man Keanu has since developed symptoms of tubercular leprosy.

The disease in the case under consideration, began without any of the usual prodromal or febrile symptoms, its first appearance being indicated by a bluish-red, slightly elevated patch about the size of a threepenny piece, situated over the left eyebrow. The patch was anaesthetic, so that the patient incised it with his penknife without producing any pain. A few weeks subsequently, a similar nodule developed over the right eyebrow, and soon
afterwards another showed itself in the centre of the forehead, the position of the latter being at present indicated by a scar. From this period the disease began to spread rapidly over the face, manifesting itself by the appearance of fresh nodules, which at first were separated by patches of healthy tissue, but later on they became fused into a sheet of leprous infiltration. About three months after the first appearance of the disease on the face, two coppery-coloured, non-raised patches appeared on the dorsum of each foot. These patches were followed by a succession of similar ones extending up the legs and thighs, and on to the trunk.

Present Condition.—All parts of the body surface are affected with leprous lesions, except the skin over the front of the chest and the abdomen. The head and face are more extensively affected than other parts, the face appearing to be a mass of confluent lepromata, which, however, commenced as isolated patches of a bright scarlet hue, some of which have retained their colour, others have faded to a bluish or brownish tint, presenting an appearance not unlike disappearing ecchymoses; the whole face is much swollen, and those of the tubercles that are at present isolated, stand out about one-third of an inch above the surrounding level of the apparently healthy skin. The affected skin feels dry, tough, and leathery, with a glazed appearance. The nose is much swollen, due to leprons deposits in the skin and the lining mucous membrane. The ears are affected to a less extent. Cutaneous sensibility is much diminished wherever there is infiltration of the tissues of the face. The scalp is affected and tubercles extend as far back as the coronal suture. The arms and legs are extensively affected, but the lesions present a marked clinical difference from those described on the head and face. They consist of coppery-coloured patches, varying in size from a split pea to three or four inches in diameter; they are for the most part circular in shape, but some adjacent ones having become confluent, large irregular patches have been formed. There is but little alteration in the consistency of the skin in most of the patches, but in some of them there is a certain amount of infiltration perceptible to the touch. Cutaneous sensibility is diminished, or even absent in some, in others it is somewhat increased, and again in others it seems to be normal. The patches on the arms and legs are symmetrical, and follow to some extent the course of some of the larger nerves, especially the musculo-spiral in the arm and the musculo-cutaneous in the leg. On the back of the hands, the skin
is of a deep purple, the hands and fingers are much swollen and infiltrated with leprous deposits which, according to the patient, have never in this position been of patchy distribution. On the back, the patches resemble those on the arms and legs, but the distribution is non-symmetrical, and without any special relation to the nerve branches. The nervous symptoms are marked, the cutaneous sensibility being much altered, not only in the majority of the patches as described above, but also in the vicinity of these patches, in skin which is otherwise apparently normal. A few months ago, patient knelt upon a hot water pipe without knowing it; he did not feel any inconvenience at the time, but on going to bed he found the part blistered and inflamed. The knee jerk is increased, but the chief superficial reflexes are normal; patient occasionally complains of "tingling sensations" in the feet. Sexual desire is much increased. There is no atrophy of any of the muscles as yet apparent.

RETENTION OF A FOREIGN BODY IN THE EYE FOR ELEVEN YEARS—CONTINUED IRRITATION IN INJURED EYE—NO SYMPATHETIC OPHTHALMITIS.

By J. W. Barrett, M.D., M.S., F.R.C.S. Eng., Assistant Surgeon to the Victorian Eye and Ear Hospital.

And Percy Webster, M.D., M.R.C.S. Eng., Resident Surgeon.

T. S., aged 48, told the following story:—Exactly eleven years ago, he was working at an anvil, and had a man to his left who was chiselling the corner off some iron. He felt a sharp blow on his left eye, and immediately lost the sight in it. He was laid up with the eye for three months, during the first week of which it was extremely painful, and he was unable to lie down, owing to the aggravation of the pain which this position of his head caused. Gradually the pain and redness disappeared, so that at the end of three months he resumed his work, seeing only with his right eye. Since then he has had at times pain and irritation in the left, lasting for a day or two, but it has not troubled him, except to a trifling extent, until within five weeks of his admission to hospital, when severe pain returned with photophobia and lachrymation.

On admission, there was slight conjunctival and ciliary injection, with a little photophobia and lachrymation, and ciliary tenderness.
Pupil 3 mm., irregular, and partially blocked by opaque tense capsule, with the iris puckered at its outer side; tension \( T + V \); \( V \) = perception of light only.

As it was thought a foreign body was still in the eye, Dr. Barrett did an outer iridectomy, to permit of ophthalmoscopic examination, with, however, a negative result, as no foreign body could be detected, and a clear view of the fundus was not obtainable. Fourteen days after the iridectomy, the pain having returned, patient consented to the removal of the eye. After enucleation, a chip of iron, the size of a small lucifer head, and weighing a trifle under a grain, was found at the bottom of the vitreous. On the fundus was a white patch, the size of a pin's head, surrounded by pigment, representing doubtless the point of impact of the steel eleven years before. The right eye was healthy; vision normal.

The writers believe that sympathetic ophthalmia is a comparatively rare disease, and have determined to put on record in brief, every case they note in which the conditions usually producing sympathetic disease are present without its production, and also all cases in which it appears.

A CASE OF PAPILLOMA OF THE LARYNX.


M. B., aged 28, married five years, two children, one miscarriage, came to the out-patient room of the Melbourne Hospital at the beginning of November of this year, complaining of aphonia, of two years' duration. She admitted that her voice had been hoarse for at least four years. She was perfectly well otherwise. She had consulted several medical men, who all agreed that she was suffering from a tumour in the larynx.

On examination with the laryngoscope, a well-marked papillary-looking growth, not at all pedunculated, of a reddish colour, was found growing from the right ventricular band, near the anterior commissure of the larynx. The surface of the growth was free from ulceration, and the movement of the cords was unimpaired. The ventricular band was swollen for some distance beyond the base of the growth, and appeared to overlap the true vocal cord upon the same side.

As the patient lived at Healesville, she was admitted as an in-patient, and I am indebted to Dr. Springthorpe for having
allowed her to occupy one of his beds. Having previously painted the fauces and larynx with a 20 per cent. solution of cocaine, under the guidance of a medium-size laryngeal mirror, I removed the growth by means of laryngeal forceps, of the pattern commonly used in the throat clinics at Vienna. The removal was completed in three or four sittings. At present, some thickening of the ventricular band still exists, but the voice is almost completely restored, with the exception of slight hoarseness.

Mr. G. A. Syme kindly examined the growth microscopically, and reports that it is a papilloma, and shows no evidence of malignancy.

This case is, I think, worthy of record, as the disease is not common, even in pure throat clinics, and is still rarer in general practice. The amount of swelling of the ventricular band made me somewhat anxious as to its possible malignancy, but the microscopical examination has negatived such an idea. The presence of the growth in this case could not be attributed to excessive use of the voice, or any other exciting cause.

Medical Society of Victoria.

Ordinary Monthly Meeting.

Wednesday, December 2nd, 1891.

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

The President, Dr. Hinchcliff, occupied the chair. The attendance of members was small.

The minutes of the previous meeting were read and confirmed.

The Secretary announced that the Legislative Council had passed the Medical Bill, and sent it to the Assembly. He had written to Mr. Turner, who said that he would not have charge of the Bill, but that he would speak to the Minister in charge of it, and ask him to do what he could to ensure its passing.

The Chairman stated that he had drawn the attention of a member of the Legislative Council to the defect in the Registration Bill, which permitted anyone to sign a death certificate, and in consequence, it was likely that early next session a Bill would be introduced to amend the Act, so that only a medical practitioner, a coroner, or magistrate (after inquiry), could give a certificate.
Dr. Neild proposed a resolution to the effect, "That the Society wishes to convey to Dr. Cutts its sympathy in the loss he has recently sustained by the death of his wife." This was seconded by Dr. Williams, and carried.

The meeting was then adjourned, and a Special Meeting called to consider the amalgamation proposals.

**SPECIAL MEETING.**

The Hon. Secretary said that the Committee of the Society, after some preliminary negotiation with the Council of the Victorian Branch of the British Medical Association, had appointed a sub-committee, consisting of Professor Allen, Dr. Neild, and Dr. Barrett, to investigate the subject of amalgamation. This sub-committee had reported that it was quite practicable, and recommended a scheme as a basis. This was submitted to this Committee and Council, with a request that each body should appoint five delegates—the ten members, with Dr. Henry, to form a conference to discuss the matter. These delegates were—Professor Allen, Drs. Adam, J. P. Ryan, Jamieson, and Barrett, from the Medical Society, and Drs. Neild, Shields, Syme, Gresswell, and Kenny, from the Branch. This conference drafted a scheme which was to be submitted primarily to the Committee and Council, and ultimately to the members of the two Societies. It was then considered and adopted by the Committee of this Society, and is now before the Society for discussion.

The following letter was read from Professor Allen:

**Freemasons’ Hotel, Wollongong,**

**27th November, 1891.**

**MY DEAR DR. BARRETT,—I trust that my absence from the next meeting of the Society will not be construed to imply any trace of indifference to the amalgamation proposals now under consideration. On the contrary, as you know, I have the most lively interest in them. At present there are two Societies, both possessing undoubted elements of strength, both virile and progressive. Both may be congratulated on their position. Yet in their separate existence there are evils which, though mainly potential, have not failed to make themselves manifest in past experience. The profession is apt to speak with a divided voice. This is unfortunate at all times, but specially so when it is desirable to impress the will of the profession upon the Government. On such**
occasions, disunion is disastrous. But, on broader grounds, I am convinced that strength lies in union, weakness in separation. The two Societies are doing similar work. A large proportion of members are paying subscriptions to both, and, at much inconvenience, trying to attend the meetings of both. Each Society finds it necessary to establish Sections for special departments. But if the existence of two Societies affects their general proceedings, how much more will it weaken all Sectional work. Surely there is only one wise course. Let the two Societies join together, so that the profession may speak with undivided voice on all matters of general interest. The roll of members will be strengthened. The financial position will be such as to permit the improvement of the Hall, and the further development of the Library. The general meetings will be more numerously attended, and provided with abundance of attractive subject-matter; while special Sections will soon be fully organised, in which, as far as possible, every member may find sympathy and assistance in his individual work. Let the Societies join, so that the long and honourable history of the Medical Society of Victoria, and its established traditions, may be allied with the wide interests, the strength and progressiveness of the British Medical Association. As regards the terms of union, let us be wisely generous. Let us show clearly that the future Society is to be the local branch of the British Medical Association, in fraternal relations with all other branches, especially with those in the sister colonies of Australasia. Details matter little. They can be re-adjusted hereafter as experience may direct. The one essential is union. If there be a real desire for union, all difficulties become trifles. I trust that the subject will be considered in large-hearted fashion, so that, whatever be the result, good feeling throughout the profession may abide and grow. But I heartily wish that, after careful consideration, there may be found a general concensus in favour of union.

Believe me, dear Dr. Barrett,

Yours faithfully,

H. B. Allen.

Dr. Neild said that it was necessary to commence with a proposition, and so he proposed:—"That the Medical Society of Victoria approves of the proposal to amalgamate with the Victorian Branch of the British Medical Association, and accepts as the basis of such union the terms submitted by the joint committee,
and also approves of the accompanying draft of Rules." He did not need to go into the merits of the question, as it had been considered before, and Professor Allen's letter supplied all the reasons in favour of such a union. The proposal for union came from this Society, not from the Branch, and that proposal implied a feeling in the Society in favour of union. He did not know that union was necessary, but thought it might probably be desirable. The two Societies had existed side by side for years, and so there would be no difficulty in their continuing to co-exist. Though a member of both Societies, he was not prepared to speak of the general approval of the Branch, as it had as yet held no meeting to consider the question. He thought that there was a general feeling in favour of union; but some were greatly opposed to it. The matter had been carefully considered by the Joint Committee, the Rules had been gone over, and thus a workable code of Rules had been drawn up. Very little alteration had been necessary in the Rules of the Medical Society of Victoria, but a few changes had to be made, as the other Society was a Branch of the great British Medical Association. If his proposal were carried, it would probably be desirable to go through the Rules, though as they had been drawn up by a Sub-committee from the two Societies, they would probably have sufficient confidence in them to accept them.

Mr. C. S. Ryan seconded Dr. Neild's proposal.

Dr. James Robertson said he was sorry to see so small a meeting on such an important occasion. This Society was established in 1853, and he had a copy of the Rules, printed in 1856. In these there were two rules which were regarded as fundamental, which were not to be altered by any succeeding Committee. These Rules were:

"Rule 24. That the property of this Society shall never be divided among the members, or sold for their benefit, or alienated in any other way; but in the event of a dissolution of the Society, or of the number of the members becoming less than five, and continuing so for six calendar months, the property of the Society shall be given over in trust to the Committee of Management of the Melbourne Public Library, until this Society be re-established, with the same stipulations respecting the property."
"Rule 25. That it be a fundamental rule of this Society that the 24th Rule, determining the destination of the property of this Society in the event of a dissolution or of its members becoming less than five, and continuing so for six calendar months, shall never be altered; and that each gentleman enrolling himself as a member of this Society shall be considered as pledging himself to the faithful maintenance of this Rule."

The Rules were amended in 1861, when he was secretary of the Society, but these fundamental rules were retained. In 1884 the Rules were again amended, and now this fundamental Rule was omitted. (Dr. Moore stated that the fundamental Rule was altered in a copy of the Rules printed in 1877). Rule 21 (Rule 24 above) remained practically unaltered. He thought it a grave dereliction of duty on the part of the Committee to omit the fundamental Rule. He did not think it could have been done on purpose. Rule 21 said, "The Rules of this Society shall not contravene any of the fundamental laws of the British Medical Association." Rule 22. "In the event of a dissolution of the Society, or of the number of members becoming less than eight, and continuing so for six calendar months, the property of the Society shall be given over to the Council of the University of Melbourne until the Society be re-established or finally dissolved, in which latter case it shall be sold and the proceeds transferred to the Council of the said University, for the benefit of the Medical School." He could not understand how members of this Society could be led to agree to such a Rule. Were not the wishes of the founders of the Society to be considered? The Medical Society of Victoria had existed since 1853, before the British Medical Association—the parent Society—itself existed, and the Victorian Branch of the British Medical Association had only existed since 1879. He did not think that this Society should be merged in the British Medical Association. The members of this Society, who had agreed to the Rules for the amalgamated Society, had agreed that this Society should be obliterated. He considered that they had committed treason against this Society. He did not see why the Medical Society of Victoria, after its thirty-eight years of existence, should sink its identity. He would rather see it in the future joined with some large Australian Medical Society than with the British Medical Association. Members surely had not considered what they would lose, or were they prepared to
surrender the advantages which they inherited? He had heard no argument in favour of surrendering their Hall, Library, and Journal to another body. He felt, too, that so long as five members of this Society decided to remain by it, it could not be amalgamated. He would move before anything further was done:—“That the opinion of counsel be taken as to the power of this Society to amalgamate with the Victorian Branch of the British Medical Association, such opinion to be based on the Rules of the Medical Society of Victoria, as at various times amended, and the Rules of the proposed Society.”

Mr. J. H. Webb seconded Dr. Robertson's motion. He thought that such an important subject should not be decided at so small a meeting. He also objected to the name chosen for the new Society.

Dr. Williams was very sorry and surprised to see the opposition taken to amalgamation by Dr. Robertson. As to the objection that they were not following the wishes of the founders of the Society, the only two original members living were Drs. Ford and Youl. In 1861, the following gentlemen were members:—Dr. Cutts, who is in favour of amalgamation; Dr. Youl, who resigned years ago; Dr. Ford, absent from the colony; Dr. Fisher, who had not been at a meeting of the Society since he (Dr. Williams) joined it; and Dr. M'Crae, who, he thought, was in favour of the proposal. In those days there was no Hall, no Library—the Society possessed no property. A time came when, through their dealings with the Government, they had to appoint trustees. He did not see any force in the objection to the proposal to transfer the property to the University instead of to the Public Library. Finally, we were going to amalgamate the profession rather than the Societies. He thought that if Dr. Robertson had been oftener at the meetings lately, he would have been educated up to a desire for amalgamation.

Dr. Jamieson said that one or two things might be said with regard to the new rules. As to the name; this was unsatisfactory, but it could hardly be otherwise, as it was necessary to retain both. Another point was with regard to property. It was a question whether a Branch of the British Medical Association could hold property at all; and we certainly were not going to allow this hall to fall into the hands of the London or any other Society.

Dr. Barrett said that if Dr. Neild's proposal were adopted, it would only be a proximate basis for amalgamation. The same
Amalgamation Proposals.

proposals would require to be adopted by the Victorian Branch of the British Medical Association; then, when adopted by the two Societies, the proposals would have to be sent to the parent British Medical Association, and then we would know where we were.

Mr. J. P. Ryan agreed with Mr. Webb’s remarks as to the inadvisability of coming to a decision in view of the very small attendance.

Dr. Hinchcliffe (the President) said he had thought this matter over very carefully, and he agreed with what Dr. Robertson had said. When he saw the new name, he said at once, what is going to become of our Society now; why should our Society, with its roll of 200 members, be swept away with a stroke of the pen? He, at any rate, was against amalgamation. If they wanted amalgamation, let them call the new Society by our name. To adopt the name suggested would be an insult to the founders and to the old members of the Society. He thought the matter should be postponed for some months. If brought up a number of times in succession, we would get the real opinion of members on the subject.

Dr. Kenny wished to correct a misunderstanding that the President was evidently under. The proposals for amalgamation had come from this Society, and not from the Branch.

Dr. J. P. Ryan said that, considering the smallness of the meeting, he would propose an amendment, “That the question of amalgamation be postponed for three months.”

Mr. Webb seconded the amendment.

This was carried, and the meeting terminated.

The Will of the Late Dr. Le Fevre, M.L.C.—The will of the late Dr. Le Fevre, M.L.C., has been filed in the probate office. The deceased died at Glasgow, Scotland, on the 17th of October last, leaving a will dated the 28th of January, 1890. The sworn value of the estate is £99,440, consisting of £70,191 realty and £29,249 personalty. Under the will, £1000 is bequeathed to each of his children upon their coming of age, and £250 is left to each of his brothers and sisters. In event of the estate being above the value of £50,000, the legacies to his brothers and sisters are to be increased to £500 each, and if above the value of £100,000, to £1000 each. An annuity of £250 is left to Caleb Le Fevre, the father of the deceased, and like annuities are left to Harold Le Fevre, Bedfordshire, England, and to Eleanor Le Fevre, the mother of the deceased. One-sixth of the residue was left to the testator’s wife, Sarah Le Fevre, but as she pre-deceased her husband, the residue of the estate is divided into five equal parts, and is left to the deceased’s daughter and four sons.
British Medical Association.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

Wednesday, November 18, 1891.

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

The President, Dr. A. SHIELDS, in the chair. There was a small attendance of members.

The minutes of the previous meeting, October 21, 1891, were read and confirmed.

Read, letter from Alex. McCalla, Esq., acknowledging receipt of letter of condolence sent to the family of the late Dr. Le Fevre.

Read, letter from General Secretary, British Medical Association, stating that it was against the Rules to allow the admission of legally qualified medical women as members of the Branch, but stating that the opinion of the Council of the Association would be obtained on this point.

The Honorary Secretary drew the attention of members to the month's notice, given in the circular calling the meeting, of the intention to discuss a proposed set of Resolutions and Code of Rules for the Amalgamation of this Branch and the Medical Society of Victoria.

The Hon. Secretary, for Dr. Fishbourne, read the following paper:

NOTES ON THE COLSTON CASE.

By JOHN WILLIAM YORKE FISHBOURNE, M.D.

Pressure of work, and uncertainty of time at my disposal, have hitherto prevented me from taking any notice of certain criticisms which have been made public, upon this most interesting and instructive case; but as I was the first person consulted on the matter of Colston's mental condition, and as it was on my opinion that the defence of insanity was raised at the trial, I think it is only due to myself, and those who were associated with me, to bring before this Association what I know of the subject.

On the afternoon of April 15, I received a telephone message from Mr. Marshall Lyle, asking if I would go and examine the murderer Colston in the Melbourne Gaol, with a view to advise as to his mental condition. Mr. Lyle said that the plea of insanity had been so frequently raised of late without justification, that he
would like to have my advice before raising such a plea in this case. He stated that he had seen Colston, and from his manner and talk thought him peculiar. If I thought Colston insane, he would raise that plea as a defence, if not, he would not adopt that line of defence. He also said that Colston had no money, and that therefore no matter how I advised, I would receive no fee. It will thus be seen that at the very commencement of the case, I had no inducement to make the prisoner out insane. I have little sympathy with criminals, and here my interests were all the other way. To declare the man insane meant a storm of derision from the public and press, as well as a decided opposition from all Government officials; and added to this was the loss of time involved, together with the possible inconvenience and unpleasantness of attendance to give evidence in the court.

On April 16, I first saw Colston, and noticed certain physical symptoms indicative of brain disease, which I pointed out to Drs. Shields and Mullen who accompanied me. The prisoner, however, refused to talk to me, although he knew that I came on his behalf, and that I was requested to examine him by his solicitor. I asked to be allowed to examine the prisoner alone, but this, being contrary to prison regulations, was refused. It is extraordinary, therefore, to hear that several witnesses for the Crown were not only allowed such interviews, but were permitted to make use of them at the trial. On this occasion, the prisoner gave as his reason for not speaking, that he was sick and tired of the whole affair; that what he said was not believed; that Dr. Shields poohpoohed what he said; that if he were not so continually reminded and pestered about the Davises he would forget all about them, and he would not be bothered further.

As Dr. Shields had not searched for any of the physical symptoms pointed out by me at this examination, although they were evident to Dr. Mullen, I suggested the advisability of having him examined by an oculist, as in addition to the general pathognomonic aspect—the twitching of the facial and lingual muscles, and defect of speech—the eye symptoms then noticed by me were, to say the least, very suggestive of general paralysis of the insane.

Dr. Shields agreed to have Colston examined by Mr. Rudall, but refused to allow me to be present at the examination. As he refused to speak to me in presence of others, and I was refused an interview in private, I declined to express an opinion as to his mental condition without further examination.
On April 21, I again visited the gaol. Dr. Shields expressed surprise at the absurdity of examining Colston at all. He said that he had had him examined both by Mr. Rudall and Dr. Dick, and that, so far as they had examined him, they could find absolutely nothing the matter with him. I found, however, such well pronounced evidences of general paralysis of the insane, that I unhesitatingly made it known that such was my opinion, and at the same time gave my reasons. In this, I was supported by the other medical men present, viz., Drs. Maudsley, Miller, and Mullen, one of whom went so far as to say, that if the prisoner were brought to his consulting rooms, he would have no hesitation in signing a certificate for his admission to Yarra Bend.

After an interval of nine weeks, I again saw Colston twice, and found that the disease had considerably advanced, more especially the physical symptoms, which had by this time apparently become evident to all those engaged in the case. I think I cannot do better than give here my sworn evidence at the trial:

"Dr. Fishbourne.—I know the prisoner. I first saw him on 16th April in Melbourne Gaol, Dr. Shields and Dr. Mullen (Barrister) present. I was there about three-quarters of an hour. I noticed certain physical symptoms—(1) Expression of the face; (2) A certain flattening of the right side of the face, with a drooping of the upper lip—the lip was immobile and showed a peculiar stiffening; (3) The muscles of the face and nose were subject to twitchings and contractions; (4) The speech thickened and blurred; (5) The tongue was not completely under control, it was protruded in a jerky way, there were fibrillar motions of the muscles of the tongue; (6) The pupils of both eyes were unequal in size and irregular in contour. The hand-grasp appeared to be less firm than one would expect, and the knee-jerk appeared to be exaggerated. The heart was weak and the beat slow; the pulse counted fifty-two per minute. The prisoner was standing up when I counted the pulse. As to his mental state, I spoke to him about his crime. He refused to speak to me on the subject of his crime. He said he was pestered and bothered by everybody, everyone was speaking to him about it, and that Dr. Shields, who was present, poohpoohed what he said. I came to the conclusion that he was suffering from organic disease of the brain, but I declined to express an opinion as to his exact mental condition. I saw him on 21st April at Melbourne Gaol. Present,
Dr. Shields, Dr. Mullen (Barrister), Dr. Miller, and Dr. Maudsley. The interview lasted over an hour and a half. I observed much the same physical symptoms as on the first visit, only more exaggerated. The twitching of the face had extended to the forehead. He had a fit of uncontrollable emotional laughter without apparent cause, and for which he could give no reason. He said, when asked why he laughed, "'Pon my soul I can't tell." He spoke freely about himself and his crime. I next saw the prisoner on 8th July at the Gaol. Dr. Shields, Dr. Rudall, Dr. Springthorpe, and Mr. Carnegie, the dispenser, were present. I observed the prisoner was apparently in much better bodily condition—he was fat. The physical symptoms detailed before were increased; the twitching of the face had extended to the other side; his speech was thicker; the tongue was not now in the same condition as on the two previous visits; the pupils were more contracted, but they were still unequal in size and irregular in contour; the sympathetic reflex was entirely absent. If you irritate the skin in the neighbourhood of the eye of a healthy person, the pupil dilates and contracts again. In this case it was absent; not so in health, so far as I know. The gait was more unsteady; he staggered a little, though his footstep was firm. I observed, as to his mental capacity, an indescribable mental apathy—an obtuseness. His pupils showed an emotional mobility, dilated and contracted when his emotions were aroused. In speaking of the crime, he said that it appeared different to him from what it would have appeared at other times. He could not see that he had done anything very wrong, though he confessed that formerly, if he had thought he had committed such a crime, he would look at it in a different way—with horror. I think he is suffering from general paralysis in the first stage. Persons in this stage of the disease are not usually found in lunatic asylums. I have examined him thoroughly. I have no doubt he is suffering, in the first stage, from general paralysis.

"Cross-examined.—On the first occasion, I did not examine for sympathetic reflex of the eyes. Twitching is observed in other diseases; also drooping of the upper lip. In no other disease have you the peculiar pronunciation or thickness of utterance—I cannot describe it—it is manifest. I did not examine his eyes with any instrument; I am not an oculist. You find unequal and irregular eyes in sane persons. Unsteady gait is one of the symptoms of general paralysis. He once staggered, at another
time he did not put his foot down as steadily as he ought. On 12th July, he walked along the floor pretty steadily. He laughed after I examined his pupils; it lasted from half a minute to a minute—a silly, vacant, uncontrollable laugh. I don't think laughter would be caused by his being examined by so many doctors looking into his eyes. He knew I came on his behalf, at the request of his solicitor. He is intelligent, more than ordinarily so. I found no hallucination. I was not allowed to examine the prisoner alone. I would not yet expect to find any hallucinations. He could distinguish between right and wrong at the time of my examination, as far as a general paralytic can. I know of no fact that occurred to me personally, to show that Colston could not distinguish right from wrong, that was apart from what he said.

"Re-examined.—The particular twitching that Colston suffers from is not to be seen in any other disease, except general paralysis. Taking the symptoms together, the eye symptoms with the other symptoms can be caused by no other disease than general paralysis. I am positive the prisoner was not malingering or shamming; none of these symptoms could be assumed."

From what I have already said, it will be seen that there were—

(1) Certain physical symptoms, such as indicate central brain disease, and occur in no other disease than general paralysis. Some of these symptoms, namely, the facial tremors, the blurred articulation, and the general aspect are to the trained enquirer, and to the trained enquirer only, absolutely indicative of this disease.

(2) There was an absence of remorse for the horrible crimes which, in a man of Colston's intelligence, character, and history, was sufficiently extraordinary to be classed as moral perversion.

(3) There was a condition, happily described as one of "contented dulness," which is a form of the incipient dementia of general paralysis.

(4) There was a frank openness and friendliness about the man—a condition which in more advanced cases exists in a very marked degree.

(5) There was in addition a history of something like epileptiform attacks, and it must be remembered that these need not be epileptic fits, but may vary in intensity from a momentary
syncope, or loss of consciousness, to a condition of prolonged convulsive seizure. It is the experience of all experts that these attacks, unless very severe, are not looked on by a patient, or his friends, as of any importance.

Under examination and cross-examination, the medical witnesses for the Crown all admitted the existence of brain disease, past or present; but none of them could, or would, say what the brain disease might be, except one, whose diagnosis of Bell's palsy was deliberately dissented from by all who expressed an opinion upon it. I may here remark, that three of the Crown witnesses admitted in court that they had never personally diagnosed a case of general paralysis.

As showing further the strength of my contention, and the absolute weakness of the Crown witnesses, I cannot do better than quote the salient parts of the sworn evidence of some of the latter:—

"Dr. Dick, cross-examined.—It is very difficult to know whether a person has general paralysis in the early stages; there may be mental symptoms without well-marked physical symptoms, and vice versa. I do not personally know of a case where the physical symptoms appeared first. I have not read of such a case, but it is a matter of dispute. I don't know the authorities how they go. I was once an examiner at the Melbourne University. I regard Blandford as an authority. My experience is that, in cases of general paralysis, they have been mentally affected first. I have seen a great many mental paralytics. Certain of the symptoms I have observed in the prisoner are not symptoms of Bell's paralysis. I have not seen an assemblage of such symptoms as the prisoner presents in anybody else as far as I can remember. As a rule, no two cases of general paralysis in the early stages present the same physical symptoms. I will not say that the physical symptoms I observed in the prisoner are not consistent with the early stage of general paralysis. The first manifestation on the mental side may be some sudden act of violence. I don't agree with Dr. Youl, that general paralysis is only a disease made by splitting up symptoms; it is, I think, a distinct form of insanity. I have seen no patients in the very early stages of general paralysis. In my opinion the prisoner is not a general paralytic. The symptoms I observed indicate a certain departure from health. I should think there must have been disease at one time to produce them. I am not prepared to say what was the nature of the
disease. I do not regard a patient in the asylum as responsible for any act of violence he may commit. The physical symptoms I observed in Colston are:—Pupils unequal, sides of cheek unequal, tremor of lip, right side of mouth lower than the left, tongue slightly tremulous. These symptoms may be consistent with general paralysis. Loss of control of actions is one of the features of general paralysis. In some cases, when a general paralytic commits an assault, he would not attempt to defend himself. At an early stage, a general paralytic might reason and argue sharply, and defend his delusions with much acumen; he might also defend his acts. The physical symptoms I observed denote a nerve disease, I cannot say what—might possibly denote a brain disease of some kind. The early symptoms of all insanity are often minute to an outsider. The part of the brain where speech is located is intimately connected with the part where the higher functions exist. The prisoner's speech is slightly affected. I see no indication of brain disease, except these physical appearances.

I have met cases where I believed a man to be insane, but could not certify to any single fact. In such cases there would be indications in the man's manner, appearance, or possibly history; he told me he lived freely in China; he told me he never had epilepsy; I heard he fell off a chair.

"Dr. Rosenblum.—On April 24 I saw the prisoner, and on four other occasions. I examined with a view of ascertaining his mental capacity. I found him very intelligent for a man of his class; able to reason well; he showed no defect of memory; he showed no remorse nor regret for what he had done. I have had four years' experience in mental diseases; have seen a good many cases of mental paralysis. Handwriting is an important test of general paralysis. I have examined "Exhibit E"; from the handwriting of it, I would not suspect that the writer was a general paralytic.

"Cross-examined.—A change in the whole manner would be expected in general paralysis. Moral perversion is an important symptom. Colston told me he had good discharges from the army. I think it strange that a man of his intelligence should regard the offence he has committed in the manner he does. I did not think he was shamming. The physical symptoms I observed are such as occur in early general paralysis. I have not seen them in any other disease but general paralysis. I think he is not suffering from general paralysis. He does not present such mental
symptoms as I would expect to find accompanying the physical symptoms in a general paralytic. Supposing a general paralytic, in any stage, committed a murder, I would not regard that person as fully responsible; even if he knew the nature of his act, he would not be able to exercise self control during the act; if he had a knowledge of right and wrong, it would be an insane knowledge. I don't think I ever saw the handwriting of a general paralytic before he was in an asylum. The first evidence of mental defect may be some sudden act of violence. I have had cases come into the asylum that I have not at once diagnosed as general paralysis, but were found to be so by others. I still adhere to my opinion in this case. I may possibly be wrong in my opinion; I have examined cases, and although they were general paralytics, have failed to diagnose insanity. I have put down as general paralytics persons who were not. I don't think that Bell's paralysis would cause the totality of symptoms.

"Mr. Rudall, cross-examined.—I don't remember ever examining a general paralytic for the eye symptoms. I don't wish to say I have never done so. He has not the reflex dilatation. From what I have read, you may find nothing in the eyes of a general paralytic. I had no recollection or knowledge of the importance of the cutaneous reflex; I read it in a book, and then tested the prisoner. I have had no experience in general paralysis."

Coming now to the whole point at issue, the question for medical men was simply this—Given a man with certain abnormalities, what diagnosis can we come to, and leaving out of account all the surroundings of the murders (the only conclusive evidence of which was given by the unfortunate man himself), on the symptoms of the man as he stands before us, what conclusions could we arrive at? The answer was—general paralysis, and general paralysis only.

I have already given the reasons which induced me to come to that belief, and I will now advance the reasons which stand in the way of any other opinion. We would have to assume a separate hypothesis for each and every symptom. The eye symptoms, according to one witness, may be produced by tumour in the chest, by another, they were produced by nothing at all. The facial paralysis had to be accounted for by the violent and lamentable assumption of Bell's paralysis with twitchings on one side, and twitchings without Bell's paralysis on the other,
although there was no history of any such paralysis, and no evidence of the local condition of muscle and nerve, necessary on such assumption.

The attacks of sudden unconsciousness described by the prisoner, and sworn to at the trial, must have been Nature's way of protesting against the bad quality of liquor supplied near the residence of a prominent member of the temperance party.

Again, the Crown witnesses are driven to regard the blurred, pathognomonic speech as a congenital defect. The fibrillar tremblings of the tongue have to be explained by taking no notice of them. The general facial aspect must be looked on as that of an interesting criminal, whose nerves were unstrung by repeated psychological examinations. His contented dulness was assumed by him to show his regard for the fair treatment he was receiving at the hands of the public, the Press, and the Government Departments. His want of remorse was implanted in him by training received when, acting as a soldier of our Queen, he waded through the blood of African niggers, during the glorious struggles of the Ashantee wars.

And finally, his open frankness, truthfulness, and gentle demeanour, were a studied phase, partly due to the wholesome air of his general surroundings among his companions in the Gaol, and partly due to a laudable desire to assist the hand of Justice in unmistakably sheeting home to him those monstrous murders, which, without the truthful evidence he himself supplied, would never have been expiated by him on the scaffold.

If, on the one hand, we diagnose general paralysis of the insane, we completely cover the whole of the symptoms. If, on the other hand, we do not diagnose general paralysis, then we must either admit that grave nervous symptoms, always associated in the past with organic brain disease, can exist without the presence of any known brain disease whatever. Or else we must ignorantly diagnose some form of disease which will not stand the test of one minute's consideration.

Such, then, is the medical aspect of the Colston case from my point of view. I venture to think that, to the unbiassed reader, it will commend itself much more than what I must describe as the laboured unreality, conjured into existence by the ingenuity of a witness who testified that he had never personally diagnosed a case of general paralysis, and whose very words were:—"I came into the case unwillingly, at the request of Dr. Shields,
although I knew nothing of general paralysis, as he said he was being overborne by the number of adverse opinions!"

Dr. Springthorpe said:—As one who took part in what the law was pleased to call "Colston's trial," and thus interested in the comments upon that case reported in a recent number of the Australian Medical Journal, I am glad that Dr. Fishbourne has taken this opportunity of bringing forward the other side of the question. For it was unfair to consider that occasion a discussion, in which only one party was represented, and the publicity given to their one-sided debate requires to be counteracted, if the profession and the public are to arrive at anything like a satisfactory verdict. For our purpose, we may divide the case into three parts—the crime and its surroundings; the prisoner and his brain state; and the means by which a conviction was secured.

As regards the first point, both sides, especially that for the defence, suffer from the fact that it was never properly or sufficiently dealt with. Certainly, Dr. Jamieson's account in no way covers the whole ground, and in not a few instances, seems self-contradictory. Thus in one sentence, where one effect is desired, Colston is described a "steady, quiet, well-behaved man;" in another, where awkward facts have to be faced, "drinking habits" are held to be responsible for "fits," though some at least of these attacks, seem to have no connection with drink in any form. Again, we are told that things were tumbled about "so as to cause suspicion that plunder had been the object of the murder," though in the same sentence it is told how "Colston left without taking any money or property." The fiendish atrocity of the murder again is said to consist in its being "a double murder," as if that included the unprecedented violence and unnatural character upon which Dr. Neild dwelt in his sworn evidence. Colston's own account of the crime, again, is turned against him, and yet no effort is made to explain the attack of unconsciousness, the mental confusion, the strange return to the hotel and washing away of blood stains in a place in which he could be seen, the failure to get away to Mildura whilst escape was easy, the foolish project to go to see a constable (of all men in the world) with whom "to talk the matter over." These points, in view of other evidence, are difficult of explanation upon the hypothesis of sanity and intelligence; they are easy of explanation.
upon the ground that the murders were probably committed in a state of great epileptiform furor, or uncontrollable impulse in a weakened brain. Further, his reason is the common one with lunatics, viz., that his victims were plotting against him; his motive, the equally common one, a sexual charge; and the outcome, a double brutal murder, out of all proportion in both detail and totality to the requirements of the case. Again, he is considered sagacious, because he lies perdu so well for so long a time; would not mental and bodily inertia account for such conduct even more satisfactorily? Especially, in view of his subsequent capture by a frightened policeman, whilst his right hand lay upon a revolver with its chambers loaded. And a fitting climax, when he sat down and almost with glee, played the part of his own historian. Did ever sane man thus act before?

Now turn to the man himself. Here is a man against whom no one has a word to say, quite lovable according to Dr. Shields, presenting a past history of sexual excess and some drink, though without any of the gastro-hepatic or nervous symptoms of alcoholism. At the age almost sacred to general paralysis, with a record of sudden attacks of unconsciousness, this man whom everyone liked, and everyone trusted, suddenly commits a fiendish double murder under circumstances which include what has been already stated. Arrested as already described, he is lodged in Her Majesty's gaol. At first the Crown can see nothing wrong with him, even physically. The evidence becoming overwhelming, it is grudgingly admitted that there are certain physical signs, involving the eye, the face, the tongue, the speech, the expression, and the writing considered not from the ataxic, but from the thinking point of view. No other signs of physical disease can be detected. Surely even, per se, this implication of each and every emotional tract, without other sensory or motor defect, is more than suggestive of paralysis of the insane—the emotional insanity par excellence. Let us see what experts say in this connection. The eye phenomena, admitted to be present, include each and every detail given by Bevan Lewis, as was commonly found in general paralysis. Half a dozen medical men with experience in lunacy, and whose only interest in the case is a scientific one, regard the totality of physical signs as pathognomonic of the same disease. The expert witnesses for the Crown do not deny their practical identity. It remains for Dr. Jamieson, who admits his practical inexperience upon the point, to evolve two other explanations of
these physical symptoms out of his inner consciousness. One, that the symptoms are those of Bell’s paralysis, is disputed by every other witness. It will suffice to say that there is no history of any such attack. There are none of the usual sequelæ present; the facial tremors are of an entirely different order, and the eye, tongue, and speech phenomena are left unexplained. The second hypothesis, that of some nuclear degeneration is broached, only to be discarded by its author, and certainly needs to be mentioned only to be dismissed. If, then, we are to explain the admitted symptoms, there remain only the motor areas in the cortex, and the ideo-motor changes in the frontal lobes. In one or other the disease must be seated. As regards the former, I challenge any one to give a single recorded instance of any case of disease of the motor areas presenting the symptoms found in Colston’s case. With some experience of the literature and symptomatology of cortical and cerebral disease, I venture the opinion that it would be impossible to produce the totality of symptoms by any disease limited to the motor areas. We are thus driven to the ideo-motor areas—the anatomical basis also of the emotions and the intellectual processes—and it cannot be denied that disease of these areas is sufficient to produce the physical symptoms of the present case. This being the case, I think the opinion which I gave in Court not only justifiable, but the only justifiable opinion, viz., that it is more charitable and probably truer to consider the physical symptoms as connoting emotional and intellectual unrest and disease, than to maintain the opposite. And here it is well to remind you, that general paralysis of the insane is still terra incognita with a pre-asylum stage frequently unrecognised by asylum physicians. The day, indeed, may come, and I believe is not far distant, when it will be diagnosed from its physical side alone. Thus Fagge, Vol. I, p. 670, writes:—“There are cases in which an impairment of muscular power shows itself some months before any physical symptoms develope. It has even been a question whether the disease may not run its course, without being attended at any time with impairment of the mental powers. . . . It is in the wards of a general hospital that such cases must be looked for, though as yet unrecorded. Dr. Wilks has published at least one case, in which the patient’s mind was unaffected whilst under his care, the paralytic symptoms being well marked. But he had been ill only nine or ten months, and I think that in all probability the mental symptoms afterwards developed themselves.”
In face of such testimony, it is difficult to understand the opinions expressed by some of the Crown witnesses. Had Dr. Wilks' patient committed Colston's crime, would he have suffered Colston's fate?

But Colston's case is a stronger one in favour of general paralysis than that quoted above, for mental and emotional symptoms were not wanting, though not present to the degree which makes the general paralytic diagnosable by the unenlightened.

Thus, intellectually, there was a want of readiness, an absence of initiative—a marked defect in the faculties of comparison and judgment. Where it was not sub-conscious and practically automatic, his intelligence was, in many ways, that of a child, or rather of a man whose experiences were distant and fading. Once started, his reasoning might be logical, but it was on a low level, and the start seemed outside his control. If we have regard to his evidently superior perceptive powers, his mental state might very fairly be described as one of incipient dementia. How much more perversion might have been present, it was impossible to say, for no private or uninterrupted examination was ever permitted to the defence, though always open to the Crown. Even more noticeable evidence exists as to the emotional deterioration. With commendable candour, Dr. Shields confessed that he could not understand Colston's emotional position—left alone, he was inert and apathetic to a degree; roused, his state was one of contented dulness. He seemed to have no likes or dislikes, no preferences, no sense of his position. His first act in gaol was to write to the governor about a dangerous character at large near Narbethong. His main, if not only interest, was in the welfare of his attendant—a well-known criminal, whom the authorities placed over him, whilst denying access to medical experts—his only sorrow at his early execution, that he would not be able to finish a table which he was making for Dr. Shields. Asked about his conduct and motives, he was found admiring the glint of the sun on a dynamometer. He seemed, indeed, to me, like a man in a state of pleasing delirium. No doubt he could, and did, give answers to leading questions, and would follow up certain lines of action if kept well before him; but skilful questions could suggest the answers which were desired, and the answers were forthcoming, provided his attention could be maintained. To say that such a man was in an emotional state, in which his
knowledge of right and wrong could be such as to make him fairly responsible for his actions, is, in my opinion, to degrade right and wrong to the level of momentary feelings, and knowledge to a simple automatic perception, a mere piece of instantaneous mental photography, with little, if any, other subjective basis than the impression which it has produced.

Lastly, Colston's case deserves mention here on account of the means by which his conviction was secured.

The old legal definition of insanity—knowledge of right and wrong—was adhered to, though doubly inappropriate and misleading in such a case. And since the Full Court has upheld the definition, it certainly remains for us, since we cannot convince the law of its iniquity, at least to ask—What is the standard of right and wrong by which the law judges, and what amount of knowledge constitutes legal knowledge? This we may do in our individual capacities as witnesses, if ever we have the misfortune to again attempt to serve a demented criminal, and I fancy that it will be some time before the law will give us an authoritative and satisfactory reply.

Look again at the ways of the law in connection with the case itself. No money for the defence; a full purse for the payment of Crown witnesses. The very question, is Colston a general paralytic, which was the essence of the case, not allowed to be put to the jury who are to give the verdict. The Crown may, and does, examine the accused when and how it chooses, and the opinions, &c., so obtained, may be, and are, used against him, whilst his own medical witnesses are not allowed any such privileges, and are even unrepresented, whilst important evidence is being obtained. Again, no outside expert or Board is commissioned to examine in this case of more than doubt, and no post-mortem examination of the brain is permitted, though such examination might definitely settle the question at issue, as well as prove of great scientific value. Even an appeal, where a doubtful case and a great precedent are at stake, is disallowed.

Such was the Colston case. The Crown and its advisers may, if they choose, claim the verdict as a good one, and feel unashamed at the means by which it was obtained. But after this, and Dr. Fishbourne's presentment of it, I am content to ask unbiassed outsiders, whether the verdict was not against the balance of evidence, and the means such as no lover of justice can commend. It seems indeed to me as if having taken a certain stand, the
Crown was determined at all hazards not to run any risk of being found to have made a huge mistake "Let the individual perish, provided the law remains supreme." And as has happened before, the individual perished.

Dr. MULLEN first saw Colston during a casual visit to the Gaol with Dr. Shields, and was struck by the want of remorse evidenced by him. He saw Colston again with Dr. Fishbourne. He had been asked by Mr. Marshall Lyle in the street to take up the case, but had referred Mr. Lyle to Dr. Fishbourne. As Colston's legal adviser, he had had many opportunities of seeing him alone, and remarked his lassitude, his mental hebetude, his whole idea of several innocent people being in gaol whose cases he wanted taken up. He would answer questions, but would not keep up or continue his statements. He was a great and a notorious criminal, yet even against legal advice he would talk of his crime to all. He did not want to be sent to a lunatic asylum. An ordinary murderer generally stays his hand when he has killed his victim. Dr. Neild stated at the inquest that in all his experience he had never seen a double fatal wound as in these cases. The bodies were mutilated, but Colston said that he would have chopped them to pieces only for the mess it would have made. Partly because the old woman "knew all about his murdering Davis," and partly because she was the "worse of the two," he killed her. It was also to be remarked, that general paralytics were very touchy with reference to sexual affairs. Colston covered Davis' body to keep off the flies. He went to wash his hands at a wayside hotel; he walked to Marysville to talk about the crime to the policeman, and only missed him at the double track. He avoided a man he saw because he "did not like him, and therefore did not wish to be caught by him." He did not appropriate the contents of Mr. Munro's purse at once, but merely helped himself to as much as was absolutely necessary for the time, going again for more when it was required. His moral nature was revolting at what he had to do. He did not shoot the arresting constable, because the latter "did not annoy" him. He did not shoot Foster, who informed on him, because "Foster was not a bad sort, and wanted the money reward." He gave all the evidence himself, as against himself. It was important to ask why Dr. Shields had entered Colston in the Gaol Case Book as being in good mental and bodily health on admission? Regarding the Crown witnesses, Drs. Shields and Jamieson had stated that they had never diagnosed a
case of general paralysis; Mr. Rudall had never examined the
eyes of a general paralytic as such. During one examination of
Colston by Dr. Fishbourne, at which Dr. Shields and the speaker
were present, Dr. Shields said that he had a “settled conviction”
that Colston was sane. Dr. Fishbourne remarked that we could
not diagnose by “conviction.” Dr. Shields replied that perhaps
what he had said was too strong; he should rather say he had got
an “intuition” that Colston was sane (at that time Dr. Shields
had not physically examined Colston). If it was not general
paralysis that Colston suffered from, what was it? Dr. Jamieson
swore that he had never seen a case of Bell’s paralysis with
twitchings. Again, many cases of lunacy cannot be diagnosed
without a private interview, and as a fact, the Lunacy Statute
imposes a penalty upon medical practitioners certifying to insanity
after a conjoined examination. This does not apply to the gaol,
but why not? He maintained that the Medical Officer of the
Gaol should be neutral; he should never be called as a witness if
he had been present at a medical interview by an examiner for
the defence or for the adverse side. A man in gaol, surrounded by
officials, cut off from everybody, gets a dread of those in authority.
He should always be cautioned by the Medical Officer, that all
or any statement he makes may be used against him. The legal
definition of insanity did not regard symptoms; it merely asked,
did the prisoner know right from wrong? The rule of law is for
delusional insanity to be judged by delusions. Should a law of
this kind, passed fifty years ago, be applied to general paralysis
and other forms of insanity in the present state of knowledge?

Dr. Miller wished to make some remarks with regard to the
eye symptoms. Were the pupils irregular—had the irregularity
and variability any pathological significance? Taken with the
other symptoms, the eye symptoms shown by Colston were only
seen in general paralysis. In several hundred men examined
by him since Colston’s trial, he had found only one in whom the
eye symptoms were manifested, and this man had other abnormali-
ties, patellar reflex, &c. In idiots, he had found the pupils
irregular in fifty per cent. of the cases. In patients at the Eye
Hospital, excluding changes due to local disease, the conditions
found in Colston were very rare. Irregularity of pupils, with
abolition of the cutaneous pupillary reflex, had never been found
by him in any case examined since; this combination was well-
marked in Colston.

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Dr. Shields had had impressed upon him, by hearing the paper and the remarks thereon, how possible it was for honest men to differ widely with regard to what they see. On his own convictions, he could not conscientiously write as Dr. Fishbourne had done—he would be decidedly exaggerating. There was a reasonable explanation of another kind for many of the statements made. He had had a very good opportunity of observing Colston; he saw him every day, took his pulse, temperature, respiration—he knew Colston's would be a cause célèbre, and paid great attention to it. He was not in doubt in his own mind as to whether he made good or careful examinations. Dr. Fishbourne had said that he (Dr. Shields) stated that Mr. Rudall could find nothing wrong. Now, Mr Rudall came into the case only as an expert oculist, not as a lunacy expert, and at the time of which Dr. Fishbourne wrote, Mr. Rudall's examinations were, to his (Dr. Shields') certain knowledge, not finished. Dr. Fishbourne should let Mr. Rudall speak for himself, and not make statements for him as coming through the speaker. Dr. Fishbourne referred to the pulse at one examination only; then it was slow. Was it ever again taken by him? Mr. Rudall and Dr. Dick took it also, and he (Dr. Shields) took the pulse carefully for about six weeks, and never found anything like the slowing indicated. The uncontrollable laughter and the staggering were not evident to the speaker, though present at the time at which they were said to have occurred. Dr. Rosenblum had been called for the defence, and at his first visit said undecidedly that it was general paralysis; on his second visit he found Colston better, and the previous symptoms not so marked, and he appeared for the prosecution. Mr. Rudall, Dr. Dick, Dr. Jamieson and the speaker all failed to notice any progression in the symptoms. Some expert oculist would have been called in in any case; it was not at Dr. Fishbourne's suggestion that one was called in. There were no signs of mental deterioration; Colston's mind got clearer. At one time it puzzled him to know why Colston would not admit that he had done anything wrong, but Colston had said to him—"It's all very well saying what I should have done, when sitting quietly and not annoyed, but when I saw that old man in collusion with the old woman, my blood got up; I saw they were going to do an injury against me by charging me with rape, than which I would rather be charged with murder; also the low cunning way in which they got it up annoyed me. It was
just a question whether they were going to blot my character with a stain which could not be disproved or removed. I felt that I was not doing wrong, and that they were not fit to live. If you say it was against the law, I know that; I know the mess I am in, and will stand it like a man.” Colston had had different views years ago, but now was a sort of Agnostic. “Wasn’t there a murderer in the first family, and in the ages since, then? Were there not repetitions, duels, whole regiments sent to be slaughtered and called the glory of war.” He (Colston) felt it was a just retribution to cut these people (Davises) off the face of the earth. After sentence had been passed, he asked Colston how he was pleased with the trial; did not his side fight well? “Very well; much what I expected; my friends aimed at too much in trying to bring me in insane.” The day before his execution, after having accepted Christianity, and that only after careful consideration, Colston said—“My conduct to the Davises was cruel and unjustifiable.” Was this like a man with no remorse? His contented dulness was explained by his improved surroundings, in being removed from the ordinary cells to the hospital; he said, “I feel improving and better able to meet my fate.” Once he (Dr. Shields) said to Colston—“Colston, you are very upset before your trial.” Colston replied—“Don’t you think, as a medical man, I would be unfitting myself to meet my fate; it would be no use, I’ve murdered them, I don’t deny it; I expect to be punished.” In his (Dr. Shields’) opinion the appreciation, and the facing of the inevitable boldly, was an indication of a strong mind.

Dr. Springthorpe had remarked that the physical symptoms were grudgingly admitted. As a matter of fact, he (Dr. Shields) went three separate times to the Crown Prosecutor to have the trial put off for a month at a time, and he also consulted an Asylum physician, and was informed that three months would be a reasonable time to delay the trial, in order to watch possible developments. Was not that legal fair play? In all that time there was no progression. Again, Dr. Springthorpe noted that Colston, whilst in Gaol, instead of being concerned about himself, wrote to the Governor of the Gaol with reference to a man at Narbethong. No such thing happened. What did happen was as follows:—

After Colston had been some time in Gaol, and in the Gaol Hospital, he (Dr. Shields) asked him to write something. Colston said he would write about a man at Narbethong who was likely to do mischief, and of whom he thought the police should know.
He (Dr. Shields) found on enquiring from Mr. Foster, that everything Colston wrote in that letter was correct. Colston did not write to the Governor of the Gaol, and he only wrote that letter at his (Dr. Shields) request. The reference made by Dr. Mullen to the entry in the Case Book at the Gaol, was perfectly true; it was jotted down as his first impression. Again, what Dr. Mullen had said with reference to the first visit of Drs. Fishbourne and Mullen, was also true. He stated that he had not examined Colston on the physical side, but from conversations that he had had with Colston, he was of opinion that he was perfectly sane.

Dr. Mullen, on behalf of Dr. Fishbourne, would like to ask this question—With all the physical signs noted, if these be not general paralysis, do they exist in the perfectly healthy; if not, from what disease was Colston suffering?

HOSPITAL FINANCE AND MANAGEMENT.

The Melbourne Hospital is again en evidence. This time it is its financial condition that challenges attention. How far the Balance Sheet is the result of the criticism passed upon the site, construction, mode of election of the staff, and general management of the Institution, it is difficult to say. Probably the present deficit is in the main due to the hardness of the times, as all the Hospitals find their revenue diminished, though not to the same extent as the Melbourne Hospital. What is a reasonable sum to expend per occupied bed in a hospital, due regard being paid to securing efficiency, is a question that has not yet been solved. A reference to the reports of the Inspector of Charitable Institutions, shows that most extraordinary differences exist in this respect in the various hospitals in Victoria. In the Report for the year ending June 30, 1891, just to hand, the cost per head for daily average of in-patients varied from £118 19s. 11d. at the Women's Hospital, Melbourne, to £37 14s. 7d. at Dunolly, and this latter expenditure includes extensive
repairs to buildings during the year, so that if these be
allowed for, the cost at Dunolly would be reduced to
£34 13s. 4d. per head. The returns unfortunately give no
details of expenditure, so that it cannot be ascertained in
what departments great expenditure is incurred, whether for
provisions, alcohol, domestic expenses, drugs and dressings,
salaries, or expenses of management. A similar discrepancy
in regard to cost is noticeable in Great Britain, where it has
attracted much attention and much anxious thought, with
the object of securing greater uniformity. According to
Burdett's Hospital Annual for 1891-92, in one general hospital
(the Miller Hospital), the average cost of each bed occupied
was £213 7s. 8d., and the lowest was £18 19s. 8d. for a
children's hospital in Derbyshire.

The cost per head for daily average of in-patients at the
Melbourne Hospital is £112 2s. This is surely too high,
but in what particulars, we have no means of ascertaining.
One item in the returns of the Inspector is noticeable. The
number of nurses is seventy, and the daily average of patients
270, or nearly one nurse to four patients. How many of
these are pupils is not stated Nursing is rendered very
laborious at the Melbourne Hospital, by the want of
appliances. There are no lifts, and all the food, drugs,
dressings, bedding, &c., has to be carried upstairs. There
are no shoots, and all the dirty linen and refuse has to be
carried down. Many of the wards are a long way from the
kitchen and laundry. Many of the wards are small, so that
as each ward has its sister, or head nurse in charge, more
sisters are required than if the wards were larger.

A sub-committee has been appointed to investigate the
expenditure in the hospital, and if it does its work properly,
it will almost certainly find much extravagance and waste.
But will the sub-committee do its work properly? Why
should a sub-committee be required? The Committee itself
ought to be thoroughly conversant with the arrangements
and expenditure of the Institution it is supposed to manage.
As long as the Committee is a large body, composed of men
with no knowledge of hospital affairs, and too busy with
other matters to do more than occasionally attend meetings, and waste time in talk which simply displays their ignorance of what is being done in the hospital, and still more of what ought to be done, so long will hospital disputes and financial and other difficulties exist, with necessarily diminishing efficiency. What is wanted is a radical change in the mode of management. The governing body ought to be a small one, and composed of men who are willing to devote some time to studying the requirements of the hospital. The Medical Staff should be represented on it, and act as its expert advisers. The Government ought also to nominate members, who should especially see that the Government grant was not squandered.

In his report, the Inspector of Charitable Institutions suggests that he ought to have more power of interfering in the arrangements and management of the institutions he inspects. It is rather doubtful whether it would be wise to put much executive authority of the kind suggested in the hands of an individual, but much might be done by the Government, either through its nominees on the Committee, or directly, by refusing the annual grant if certain reforms were not carried out.

Review.


We have read the work before us with the greatest pleasure, as indeed we should all efforts which tend to elucidate the subject of Hydatids — this almost peculiarly Australian scourge. Although hydatid is one of the commonest maladies with which we are acquainted, its literature, except such as can be picked up from the weekly and monthly journals, is extremely scanty. We believe that the excellent little brochure of Dr. S. D. Bird was the first which called attention to the frequency of this malady and to its rational treatment. Since then, surgeons such as Volkmann, Lindemann and others, in Germany, and Lawson Tait, in England, in the course of the development of abdominal surgery, elaborated
the now generally recognised method of radically dealing with the
cyst. The works of Dr. Thomas, in Adelaide, are well known to
all Australian practitioners, and to him and to Dr. Gardner, of the
same town, unquestionably great credit is due for so consistently
and strenuously advocating the radical treatment initiated by
Lindemann.

The author commences with an introductory chapter, dealing
generally with parasitism as it affects the human subject. Then
the sources and distribution of hydatid disease are clearly discussed,
and certain prophylactic precautions are suggested. The tenia
echinococcus is traced, and somewhat fully described, through its
whole development. Then the hydatid cyst as found in man is
dealt with, and is described in considerable detail. This part of
the work is almost wholly the result of very careful compilation.
It is a pity that the author does not use the term ectocyst with
the generally accepted meaning, viz., the outer or laminated
portion of the mother cyst, instead of the adventitia or fibrous
layer, formed from the tissues of the organ in which the cyst is
located. A short chapter is devoted to the general symptoms of
hydatids, another to the diagnosis of the affection, whilst the
hydatid rash receives itself a chapter longer than the other two
together. Separate chapters are devoted to the description of
hydatids in all the various parts of the body, except the
subcutaneous, intermuscular, and muscular structures, in the
former of which sites they are by no means uncommon. There
is a marked unevenness in this portion of the work, the chapter
on hydatids of the liver being very brief, whilst that on the lungs
is much longer; that on the disease as affecting the brain is much
longer than that on hydatid of the peritoneum. The remainder of
the text is devoted to the consideration of the treatment of the
disease and to notes of cases. In his discussion of treatment, the
author adopts the arguments urged by the Adelaide surgeons
against tapping and in favour of the more radical dealing with the
cyst by free incision and drainage. The cases described are most
of them such as are ordinarily met with in large hospitals, and
give a good idea of the nature of the disease from the clinical
standpoint.

It only remains to say that the book has been got up in the
way that a book should be. The paper is good, the type is large
and clear, the margins are wide, and considerable care must have
been taken in reading the proofs, as very few errors remain in the
text; altogether, the book is one that it is a pleasure to read. Too much cannot be said in praise of the plates; they are as nearly perfect as possible, showing clearly the various conditions in connection with the disease. The book is a decided acquisition to Australian medical literature.

W. M.

University Intelligence.

MELBOURNE UNIVERSITY.

The following are the names of the successful candidates in the First Pass Examinations in Medicine, held in October last:—

FIRST YEAR MEDICINE.


SECOND YEAR MEDICINE.


THIRD YEAR MEDICINE.


FOURTH YEAR MEDICINE.

Stuart Letcher Angwin, John Box, Ralph Charles Brown, William Thomas Chenhall, Charles Arthur Courtney, Alfred

**Fifth Year Medicine.**


The following is the result of the recent Honour Examinations in Medicine:

**Second Year.**

*Junior Descriptive and Surgical Anatomy.*—First Class—Harold Lister. Second Class—None. Third Class—Thomas Ernest Green and Oscar Rudolph Percy Müller, equal; Arthur Edward Blackett Forster.

*Physiological Chemistry and Histology, and Materia Medica, Medical Botany, and Elementary Therapeutics.*—First Class—Harold Lister, Herbert George Tymms. Second Class—Oscar Rudolph Percy Müller. Third Class—Mary Elizabeth Diggle Fletcher.

**Third Year.**

*Senior Descriptive and Surgical Anatomy.*—First Class—Louis Naish Ashworth, David McMaster Officer. Second Class—Emily Mary Page Stone, Frank Cole Madden.

*Physiology.*—First Class—David McMaster Officer, Patrick Paul Dowling. Second Class—Emily Mary Page Stone. Third Class—Louis Naish Ashworth.

**Fourth Year.**

*Regional and Applied Anatomy and Pathology.*—First Class—Thomas Alexander Wilson, Ralph Charles Brown, David Thomas


### Exhibitions.

**Second Year Medicine.**—Junior Descriptive and Surgical Anatomy, to Harold Lister. Physiological Chemistry and Histology, and Materia Medica, Medical Botany, and Elementary Therapeutics, to Harold Lister.

**Third Year Medicine.**—Senior Descriptive and Surgical Anatomy, to Louis Naish Ashworth. Physiology, to David M-Master Officer.

**Fourth Year Medicine.**—Regional and Applied Anatomy and Pathology, to Thomas Alexander Wilson. Therapeutics, Dietetics and Hygiene, to John Alison Hawkes, William John Long, equal.

The following are some of the papers set at the recent Examinations in Medicine:

### Regional and Applied Anatomy.

1. Describe the superficial origins of the cranial nerves.
2. Describe the pharynx.
3. Describe the cutaneous nervous supply of the upper limb.
4. Describe the steps of the dissection necessary to expose the kidney from behind. Name in order the several structures met with, and state their relations to one another.
5. Discuss the surgical anatomy of femoral hernia.
6. State the normal weights of the heart, lungs, liver, and spleen.
7. Describe the movements of the foot, and name the muscles by which they are severally produced.
PATHOLOGY.

1. Describe the chief experiments that have been performed upon frogs in order to demonstrate the vascular changes which occur during inflammation.
2. Discuss calcification as a pathological process.
3. Describe the appearance, microscopic structure, and history of uterine myomata.
4. Describe the process of detachment of sequestra in necrosis of bone.
5. Describe in detail the processes which occur in adhesive pleurisy.
6. Describe the changes produced in the valves of the heart by endocarditis.

THERAPEUTICS, DIETETICS, AND HYGIENE.

Paper I.

1. Give the uses and preparations of arsenic, cocaine, chloral, phosphorus.
2. Discuss the therapeutic actions of mercury, iodine, gelsemium gentian.
3. Describe the different kinds of baths and their uses.

Paper II.

1. Describe fully the different phases of the digestive process.
2. How can we influence digestion medicinally?
3. Discuss the influence of cooking upon the different kinds of food.
4. What is the minimum "air space"? How is it arrived at?
5. What do you know of the modes of entrance and of exit of the main infectious diseases?
6. Discuss the sexual instinct as a factor of personal health.

FORENSIC MEDICINE AND PSYCHOLOGICAL MEDICINE.

1. What are the usual causes of apnoea, and what are the appearances indicative of death from this condition?
2. Enumerate the several influences which retard or accelerate the putrefactive process.
3. From an inspection of the skeleton of an adult, what are the points to be looked to in determining the question of age?
4. In a case of alleged rape, what precautions are to be observed in the examination of the woman, so as to avoid arriving at an erroneous conclusion?

5. Describe circumstantially all the appearances indicative of maturity in the dead body of a new-born child.

6. What is mania, and what is dementia, and what are the points of difference between the two conditions?

7. Which of the irritants is most commonly employed in chronic poisoning, and with what diseases are the symptoms not unlikely to be confounded?

**SURGERY.**

1. What are the pathological changes observed in rickets? Detail some of the bone deformities met with in this affection. What treatment should be enjoined in a child aged, say five months, showing symptoms of rachitis?

2. What are the causes and symptoms of stricture of the rectum?

3. If suddenly called to a case of retention of urine from organic stricture of the urethra, what remedial measures would you adopt?

4. Describe the pathological appearances of a joint in simple, chronic, and suppurative arthritis.

5. Classify burns according to the system of Dupuytren. What are the causes of death in severe burns?

6. Abscess. What is meant by metastatic, caseous, chronic, residual, cold, and tympanic abscesses? Give briefly the causes, symptoms, and nature of these pus collections.

**THEORY AND PRACTICE OF MEDICINE.**

1. Describe the causes, symptoms, and diagnosis of bronchiectasis.

2. What is the nature of the condition commonly known as alcoholic paralysis? Describe its symptoms and treatment.

3. Give the main points in the differential diagnosis of bronchitis, pneumonia, and pleurisy.

4. Describe the diagnosis and treatment of whooping cough, including its complications.
5. Discuss the chief points in the causation, diagnosis, and treatment of abscess of the liver.


**Obstetric Medicine and Diseases of Women and Children.**

1. Give the divisions of the decidua, and describe their development.

2. Describe the different positions which the foetus may occupy in utero, and in each case mention where the foetal heart is most audible.

3. In pelvic presentations give the positions of the child, the prognosis, causes of foetal mortality, and treatment.

4. Briefly describe the conditions and treatment of defective development of the female generative organs.

5. In a case of retroflexion of the uterus, what complications might be present, and what treatment adopted?

6. When the suckled child vomits or is purged, what treatment would you advise?

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**Melbourne Hospital.**

The Melbourne Hospital Committee at its meeting on the 24th ult., unanimously negatived Mr. G. Godfrey’s proposal to close one or more of the wards, with a view of compelling the Government to assist the Hospital management out of its present financial difficulties. Mr. Godfrey stated that there was an overdraft at the bank of £10,000 and an excess of expenditure over income of £5000 per annum, and as all other means of raising funds seemed to have failed, he moved the resolution. A long discussion followed, in which every voice was against closing any of the wards, and Mr. F. R. Godfrey moved an amendment to the effect that a sub-committee be appointed to inquire into the whole subject. Mr. Godfrey suggested that the City Council, who had never given a sixpence to charity, might be approached for assistance; but rather than close up any of the wards, the Committee, as a last resource, could resign, and leave it to the Government or to the City Council to carry on the Hospital. The amendment was carried.
WOMEN'S HOSPITAL.

At the meeting of the Committee held on the 27th ult., a letter was read from the hon. secretary of the Victorian Infants' Asylum asking if it could be arranged that the infants of mothers brought from the hospital to the asylum should not be vaccinated before leaving the hospital. Recently two infants had been admitted to the asylum who, in a few days, developed dangerous symptoms, due entirely to premature vaccination. Dr. Rothwell Adam, in a letter to the Committee, stated that the Central Board of Health requested that the resident surgeon of the hospital should vaccinate children before leaving the institution. This had been done whenever the mothers had not objected, and with uniform success. If the Infant Asylum authorities objected to infants entering their institution being vaccinated, it could be omitted in those cases where it was known that the mothers intended going to that institution. The letter was received.

Vital Statistics.

The Government Statist's report on the vital statistics of Melbourne and Suburbs for October, 1891, shows that the births of 1510 children, viz., 778 boys, and 732 girls, were registered. The deaths registered numbered 1042, viz., 546 of males, and 496 of females, the births thus exceeded the deaths by 468, or 45 per cent. To every 1000 of the population of the district, the proportion of births registered was 3.08, and of deaths registered 2.12. One hundred and ninety-two deaths, or 18 per cent. of the whole, took place in public institutions. Of those who died, 205 were under one year of age, the total number under five years being 286. Two hundred and thirty-four deaths in October were set down to influenza, and 269 to diseases of the respiratory system, the latter probably, in most cases, supervening upon the former complaint. The total number from influenza and respiratory diseases combined is thus 503, as against 314 in the previous month. No death from typhoid fever was registered in October, and only 7 deaths from diphtheria, the latter being the smallest number since last January.
DEPARTMENTS PRODUCED BY IODOFORM.

To the Editors of the "Australian Medical Journal."

DEAR SIRS,—You might publish the fact that I have at present under treatment a case of dermatitis, produced, I believe, by iodoform. In the same patient, a reddish punctiform rash was produced a day after the administration of K.I., and removed by a dose of mag. sulph. My case is the same in character as that described in the November number of the Journal. The iodoform, used for a sloughing ulcer on the toe, produced pustules and a rash half way to knee.

Dandenong, November 24th, 1891.

THOMAS HODGSON.

Local Subjects.


HEALTH OFFICER.—The following appointment has been confirmed:—North Yarrawonga Shire—Edward Francis O'Sullivan, M.D.

ACTING HEALTH OFFICER.—John Dunbar Tweeddale, M.R.C.S., has been appointed Acting Health Officer for the Port of Port Phillip, and Superintendent of Quarantine, from the 4th November, 1891, during the illness of Dr. Browning, the Health Officer.

Horace Frederick Hayes has been appointed a Surgeon on probation, with the relative rank of Captain.

Surgeon Hubert Lindsay Miller, M.D., has been appointed to be Surgeon-Major, vice Surgeon-Major G. Le Fevre, M.D., deceased.

Surgeon William Lowell Mullen, M.B., from the Unattached List, to be Surgeon, vice Surgeon H. L. Miller, M.D., promoted.

MEDICAL PRACTITIONERS TO EXAMINE PATIENTS IN LUNATIC ASYLUMS.—The following appointments have been made:—Ararat Lunatic Asylum, George Palmer, M.B.; Beechworth Lunatic Asylum, David Skinner, M.B. et Ch. M.; Kew Lunatic Asylum, Roderick Aitchison, M.A., M.B., Ch. B.; Sunbury Lunatic Asylum, J. De Burgh Griffith, M.D.; Yarra Bend Lunatic Asylum, Thomas Hodgson, M.B. et Ch. B.

Professor Allen’s report on hospital construction and management was presented to Parliament on the 9th inst. The Professor spoke in high terms.
of most of the hospitals which he visited during his recent trip to Europe, particularly of the new general Hospital at Hamburg, which he described as the most perfect institution which he saw during his travels. The Melbourne Hospital did not come in for similar commendation, the Professor describing it as "an awkward congeries of buildings huddled together in disorderly fashion, so that the free passage of air between them was prevented as much as possible." In the matter of construction it was discreditable to Melbourne, but its management was cleanly and careful. The patients were not under the best conditions for recovery, and if life and death were in the balance, the evil structural character of the Hospital must occasionally determine the result against the patient. Although an improved hospital might be built on the present site, the site which commended itself to Professor Allen's judgment was that now occupied by the Horse, Cattle, and Pig Market of the Melbourne City Corporation, which could never be closely surrounded by other buildings, and yet is little more than a mile from the General Post-office.

The members of the Royal Commission on Charities are rapidly closing their labours. On the 20th ult. they examined, in the person of Dr. Gresswell, Medical Officer of the Board of Public Health, who read a valuable paper on "Isolation in Cases of Infectious Disease." Dr. Gresswell maintained that to ensure absolute isolation, it would be necessary to build either a large central hospital for contagious diseases, or two or three small hospitals on the outskirts of the metropolitan area. As a start, these hospitals should have a capacity of 400 beds, of which 100 should be in permanent buildings, 100 in buildings of a less permanent character, and 200 practically available for an emergency. The cost of supporting these hospitals should be borne by the municipalities, and should be levied in the form of a metropolitan general rate, and the board of control should be formed of delegates from the various municipalities. The Commission has since held a number of sittings, at which their final report was fully considered. The report has now been adopted, and is almost ready for presentation to Parliament.

BIRTHS.

ADAM.—On the 27th ult., at Carlton-house, East Melbourne, the wife of Dr. G. Rothwell Adam—a daughter.

Alsop.—On the 10th ult., at Bonsal, Upper Hawthorn, the wife of Dr. T. O. Fabian Alsop, of a daughter.

Bennie.—On the 13th ult., at Lansdowne, Coalville, Gippsland, the wife of A. B. Bennie, M.A., M.B., B.S. (Melbourne)—a daughter.

Macansh.—On the 23rd ult., at Goombah, Church street, Middle Brighton, the wife of Wm. Macansh, M.R.C., C.M., of a son.

MARRIAGES.


Lang—Wischer.—On the 12th ult., at the Lutheran Church, Eastern Hill, by the Rev. H. Herliet, Matthew Lang, M.B. et Ch. B., of Yea, only son of Matthew Lang, of Terang, to Sabine, eldest daughter of W. H. Wischer, of St. James' Park, Hawthorn.


DEATH.

Cutts.—On the 22nd ult., at Ratilgar, Upper Hawthorn, Jane, wife of W. H. Cutts, M.D., in her 55th year.