NOTES ON CASES OF ABDOMINAL SECTION.

By F. C. Batchelor, L.R.C.P., M.R.C.S.
Honorary Medical Officer to the Dunedin Hospital.

(Continued from page 244.)

CASE V.—M. F., æt. 30, married in the beginning of 1881. Consulted me three or four months afterwards in consequence of abdominal enlargement, which she had only recently noticed. Menstruation remained regular. On external abdominal examination I found a tumour about the size and in the position of the pregnant uterus at from the fourth to the fifth month ; I could not, however, hear the foetal heart. I told the patient she was probably pregnant, but I desired her, if menstruation continued and she remained uncertain, to send for me again in two months, when the diagnosis would be certain. I heard nothing more of her till October 1st, 1882, when she again consulted me. Menstruation had continued to be regular, the abdominal enlargement had immensely increased, and presented all the appearance of a large ovarian tumour filling the abdominal cavity. I passed a fine needle to make sure of the diagnosis, and to my astonishment drew off perfectly clear hydatid fluid. The following day I aspirated the sac of between five and six pints of fluid, reducing the size of the abdomen very considerably. For some weeks she remained fairly well, but she noticed the abdomen again filling, and on the night of November 3rd, 1882, she was suddenly seized with excruciating abdominal pains and rigors, and on the morning of the 4th the abdomen was distended and extremely tender, her pulse being 120, temperature 102°. Dr. Maunsell, who had assisted me throughout with the case, saw her in consultation, and we agreed that her best chance lay in freely laying open the sac. On the following day, assisted by Drs. Maunsell and De Zouche, I laid open the abdomen by a median incision, commencing about two inches above and carrying it about four inches below the umbilicus; the sac was not adherent on the surface, and was drawn into the wound and tapped with an ovarian trocar. Thick purulent matter welled through for some time, but the

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tube soon became obstructed with loose cysts. I then attempted to pump out the contents with a Higginson's syringe, but this also became choked. Finally I had to enlarge the incision into the sac, drag it well through the abdominal walls, and clean it out with sponges and remove the fine lining membrane. I then attempted to clear the thick outer cyst wall, but the deeper I went the thicker became the cyst, and the more adherent to surrounding tissues, so after cutting off about two-thirds I thought it best to desist, the cyst-wall at this time being nearly a quarter of an inch thick, and dipping down somewhere very near the spine, though I did not ascertain where it sprang from. The wound was dressed in the usual way. Vomiting was the only trouble after the operation. A thickish blood-stained fluid exuded through the wound near the umbilicus for some ten days or a fortnight, again pointing to the necessity for drainage, but this gradually dried up, and the patient was able to leave her bed about three weeks after the operation, and is now perfectly well. Looks, and says she feels, better than she has done for years.

Case VI.—E. C., aged 33, married nine years, no family. Some eight years ago had an attack of pelvic inflammation, resulting in the formation of an abscess, which has more or less invalided her ever since. Every three or four weeks she has attacks of pain about the pelvis, accompanied by fever sometimes. These attacks are so severe that they keep her to her bed for weeks together. There is a constant discharge of pus from the bowel. Her general health is getting seriously affected, and the disease shows no signs of abatement. She has been under the care of several medical men, but nothing has ever given her any permanent relief. The aspirator has been used on several occasions, but no matter has ever been drawn off. I saw her first in consultation in the summer of 1881; there was then a large hard smooth mass filling up the left iliac region, its upper limit being on a level with the umbilicus, and passing below into the pelvis, surrounding the os, and fixing the uterus, which it displaced to the right. The bladder was also pushed on to the right.

In April, 1882, she came to town to see if anything could be done to cure her. She was repeatedly suffering from the attacks of severe pain; was losing flesh and strength, and was in fact feeling that the disease was wearing her out.
and that her life was not worth living. I found the tumour much in the same state as when I had previously seen it; a smaller swelling was also now beginning to form, apparently in the right broad ligament. Pus was passing daily from the bowels. I passed a needle on several occasions into the large mass on the left side, both from the vagina and through the abdominal walls, but never succeeded in drawing off pus, although that there was matter formed was certain from the daily discharge from the bowels. The nature and prospects of an operation were fairly laid before her, and she decided on an attempt being made for her relief by abdominal incision.

On April 18th, 1882, assisted by Drs. Drysdale, Brown, and De Zouche, I laid open the abdomen by a median incision from near the umbilicus to the symphysis. No adhesions were found to exist between the sac and the abdominal wall, but on opening the peritoneum the mass came at once into view, covered by thickened velvety-looking peritoneum. I plunged Cox's trocar into the lower part of the sac, and after passing through a tough thick cyst-wall felt it enter a cavity. On removing the trocar, thick and horribly fetid matter welled up; this I carefully kept from the wound, and after allowing a few ounces to drain away plugged the canula. I then carefully closed the abdominal wound, and kept it aseptic and quite separate from the opening of the canula, which was afterwards fastened in. The abdominal wound healed without trouble, although vomiting was as usual the source of danger and a constant anxiety for many days. The was no constitutional disturbance of any moment, the pulse never being above 106, nor the temperature above 100°. I daily removed the plug, and allowed about an ounce of pus to drain away, which was so fetid that it not only sickened the patient but also the nurse.

On the tenth day after the operation, when the wound had healed, a fine catheter was passed through the canula, and an attempt made to wash out the sac; for some reason this could never be satisfactorily accomplished, pus always flowing freely immediately on removal of the plug, but the lotion injected returning unaltered. The canula was kept in about a month, and then removed for a gum elastic catheter, to allow the patient to leave her bed. The tumour during this time had very materially decreased, but still pus used to come
away daily, and I felt doubtful as to the drainage being sufficiently free.

On June 24, as discharge was still coming away, and the sac was not decreasing, I passed a curved silver canula I had made for the purpose through the fistula, and brought it out by the vagina to the left and in front of the uterus (the bladder being still displaced to the right). Through this canula a double elastic drainage tube was passed and tied in after removal of the canula; through this pus discharged freely, and the sac rapidly decreased. The swelling in the right groin disappeared shortly after the first operation. After a month I removed one tube and subsequently the other, substituting a horsehair drain from which I removed a few hairs at a time. All the wound is now entirely healed externally, nothing abnormal can be felt, but on bi-manual examination some thickening can still be detected in the left iliac region, and the uterus remains fixed to the left side. The bladder has gone back to its normal position. The patient’s general health has immensely improved; there have been no more attacks of the inflammatory nature. On the whole the operation has been successful, though the treatment required has been very tedious and prolonged. There is also, I regret to say, a hernia at the lower part of the line of incision, doubtless due to the tube having been worn so long in the abdominal wall, but this condition can I think be easily remedied by operation if occasion requires.

Case VII.—M. C., aged 54. A stout healthy country woman who has had a large family. Consulted me about November 18th for a hardness and pain about the navel. I found the umbilicus excoriated and fissured and surrounded by a button-like ridge of hard tissue. Microscopic examination showed degenerated epithelial cells and nest-like formations characteristic of epithelioma. Assisted by Dr. De Zouche I removed it on December 2nd, 1882, and in so doing had to lay open the abdominal cavity. I sewed together the peritoneal surfaces with fine catgut sutures, and used different and stronger sutures for the more superficial structures, the adipose tissue being nearly one inch thick. Listerian precautions were not so thoroughly carried out as I could have wished, as I had not anticipated laying open the abdominal cavity. Suppuration occurred in the adipose tissue, and the wound healed slowly by granulation, considerably delaying recovery; but she finally
left for home about three weeks after operation. About the end of January she consulted me again for symptoms which made me fear some malignant mischief starting in the stomach. I was away from home during the month of February, and have seen nothing of her since my return.

**Case VIII.**—M. G., aet. 24, married four years, one child three years old. Consulted me in April 1883 for a tumour in the left iliac region. It was very hard, somewhat irregular, and moveable. It seemed beneath the abdominal muscles, but by vaginal examination was found unconnected with the pelvic organs. An exploring needle was attempted to be passed into it, but was nearly broken by the toughness of the mass. As it was increasing in size and causing pain, on May 6th, assisted by Drs. Maunsell and De Zouche, I proceeded to remove it. The incision was made over the tumour and along the outside border of the left rectus muscle; the different tendinous expansions of the muscles were very troublesome, and the bleeding was considerable. The peritoneum was continuous with the tumour, and could not be separated from it; I therefore had to enlarge my incision upwards, and opened into the peritoneum above near the level of the umbilicus, cutting down to and finally dissecting out the tumour. The operation was much more difficult than one would have at first anticipated. The growth was about the size of a hen's egg, encapsuled, externally composed of almost pure white fibrous tissue, but towards its centre more greyish and softer; sections of this portion showed the fibrous stroma to contain abundance of irregular-shaped cells. On the eighth day the wound had entirely healed throughout. There has been but little constitutional disturbance, the pulse never reaching 100, and the temperature never being above 99° after the second day. The tongue has been however unusually coated, and a feeling of nausea has been more persistent and troublesome than usual; this I think must have been due to a slight attack of nephritis, as I found the urine on the fourth day somewhat smoky, and containing a small quantity of albumen, due probably to the prolonged exposure to wet from the spray during the operation. There have been no symptoms of carbolic acid poisoning apart from the urine.
ANOMALOUS CASES IN CHILDREN'S PRACTICE.

By W. Snowball, M.B. Melb. &c.
Honorary Surgeon to the Children's Hospital.

General Paralysis after Diphtheria—Death from Apnoea.

M. M., four years old, female. On the 5th June, 1883, the child was brought to me for examination. The mother told me that the child snored a great deal in her sleep, and lately her voice had a nasal intonation. I was told that four weeks previously she had what her medical attendant called an attack of "ulcerated sore throat," which lasted about seven days, and that her present symptoms dated from that period.

The child is a fine healthy-looking little girl, with well nourished limbs. The present appearance of her throat fully bears out the previous diagnosis of ulcerated sore throat; the tonsils are greatly enlarged, a scar on one side looking like the healed remains of an ulcer. No paralysis of the palate muscles; swallows well, and in fact only presents the symptoms of hypertrophied tonsils. She was ordered tannic acid paint, and syrup of iodide of iron.

June 18th.—I was sent for to see her, and found that her throat was in much the same condition, but that she had lost all power in her legs from below the knees; patellar tendon reflex was absent; the calf muscles obeyed the battery badly, and the limbs felt unnaturally cold. I said that I was afraid the original sore throat must have been diphtheritic, and that this was paralysis consequent on that disease. Ordered the child strychnine.

June 22nd.—The condition of the lower limbs unchanged, but complete paralysis of the right arm and forearm; slight ptosis of right eyelid. The next day the intercostal and pectoral muscles became affected, and in spite of artificial respiration, galvanism, &c., the child died suffocated. At no time were the throat muscles either of deglutition or speaking affected, for the child could speak and swallow till within five minutes of death.

As far as I can find, the sequence of this case is unique, for usually in paralysis after diphtheria the throat muscles either of speech or deglutition become first affected, but in this case the lower limbs were first affected, and the paralysis spread upwards. The progress of the case is another proof, if one were needed, that it is the terminal ends of the nerves that are affected, and not any change in the main nervous system.
JULY 15, 1883

Australian Medical Journal.

Hospital Reports.

MELBOURNE HOSPITAL.

Case of Punctured Wound of the Abdominal Wall, with Protrusion of Omentum—Opening Enlarged and Omentum Returned—Recovery.

Under the care of Mr. E. M. James.

Reported by F. J. Owen, M.B., Ch.B., Resident Surgeon.

J. F., aged 38, a powerful muscular man, admitted to hospital on April 28. Had been drinking heavily, and attempted suicide by first making several jagged wounds about the front of his neck, and then stabbing himself in the abdomen with a knife.

The largest abdominal wound, situated to the left of and a little above the umbilicus, was about an inch long, penetrating the left rectus and the abdominal cavity, and through it a large piece of omentum was projecting. Chloroform was administered, the patient struggling violently while being put under its influence, and the wound was enlarged under the spray. The omentum was then returned to the abdominal cavity, and two hare-lip pins inserted through the abdominal walls and peritoneum. Superficial horserhair sutures were employed and the wound dressed according to Lister's method. The wounds about the neck were also dressed antiseptically. Patient was kept under the influence of opium, and on the third day his temperature was 101°; pulse 90, inclined to hardness; breathing easy but hoarse; tongue moist. The pins were withdrawn, the upper one being much bent. There was a little suppuration about their heads, but the edges of the wound had united by first intention. There was not much tympany, and no tenderness over the abdomen. Patient had been passing wind freely. The wounds about the throat were healing rapidly.

On the fifth day the temperature was normal; pulse soft; breathing easy; opium discontinued; some tympany, but no pain.

On the sixth day patient's bowels acted spontaneously.

For two or three days the bowels acted several times a day, and then became regular. Patient was discharged perfectly well on May 14th, sixteen days after admission.
Three cases of Lacerated Wounds of the Upper Extremity.

Under the care of Mr. T. N. Fitzgerald.

Reported by G. Adlington Syme, M.B., Ch.B., Resident Surgeon.

(1.)—J. S., a pile driver, was admitted on the 19th of April with a crushed hand and fingers, caused by his hand being forcibly dragged through a block. The soft parts were completely torn away from all the metacarpal bones as far as their middle third, the thumb alone being uninjured. The patient having been anaesthetized, Mr. Fitzgerald decided to simply remove the denuded portions of bone, and leave the thumb, although some of its muscles were torn. The metacarpal bones of the four fingers were accordingly sawn off, at a level a little below the cleft of the thumb, the lacerated tissues dissected away, the edges of the skin pared, so as to form slightly oval anterior and posterior flaps. All bleeding vessels were torsioned, a drainage tube inserted and passed through an incision made in the palmar flap, wound washed with a solution of chloride of zinc, and the flaps brought together with horsehair sutures. Whole operation performed with Listerian precautions, and Lister dressings applied. Placed on an anterior arm splint.

April 20.—Temp. normal; pulse 100, strong. Slept; no pain.

April 22.—Dressed antiseptically; slight oozing of blood-stained serum on the dressings; edges of wound in perfect apposition; no inflammation about wound; no constitutional disturbance.

April 24.—Dressed; wound nearly all healed by first intention; no swelling, or sign of inflammation.

April 27.—Discharged; wound all but healed. Patient returned some time afterwards with a little suppuration in part of the hand, which was soon relieved. The motion in the thumb was perfect.

(2.)—J. F., a sailor, was admitted on the 20th of April, 1883, with a lacerated wound of the left forearm, caused by a circular-saw. The wound was about two inches below the elbow-joint, on its outer and anterior aspect, extending obliquely inwards and downwards for about five inches. The superficial layer of muscles was completely divided, and the radial artery punctured, and bleeding profusely; the bones were uninjured. The patient was sent in by a surgeon to have the arm amputated! Hæmorrhage was arrested by catgut ligatures passed round the bleeding vessel. The wound was thoroughly washed with carbolic
acid lotion, 1 in 40, a drain tube inserted, and the sides of the wound brought into apposition with deep hare-lip pins, and the skin with superficial horsehair sutures, Lister's dressings applied, and arm placed on a splint.

There was also a compound fracture of metacarpal bone of right index finger.

April 22.—Temperature went up to 103·2° last night, 100·8° this morning; pulse 120, full and strong; tongue furred; bowels confined; left arm rather swollen. Dressed under spray; some bloody oozing; in good apposition; edges red and hot; no suppuration. Right hand much swollen and tense, especially above metacarpo-phalangeal joints and over dorsum; wounds suppurating. Sutures removed; incision made on dorsum of hand. Dressed again antiseptically, and ordered a purgative.

April 23.—Evening temperature 102·6°, morning 101°; pulse 120; tongue clean; bowels acted well; did not sleep. Left arm very painful and much swollen; very tender; wound suppurating and profuse semi-purulent discharge. Three pins and several sutures removed, and wound well syringed with carbolic lotion and dressed antiseptically. Right hand not swollen or tender. The wound on the arm continued to suppurate for several days, and some sloughing occurred.

April 27.—Temp. 99° night and morning, sloughs all separated; no signs of inflammation; wound gaping in places; granulating healthily. Still dressed antiseptically, edges being coapted with adhesive plaster.

May 2.—Wound filling up from the bottom with healthy granulations; inner part of wound closed. Sponge grafts applied; antiseptic dressings continued.

May 5.—Graft taken and vascular; cavity filling up rapidly.

May 7.—Granulations shooting up into sponge. Arm kept straight, and passive motion used.

May 10.—Granulations level with surface, and cicatrizing at margins; sponge nearly absorbed; has perfect flexion, extension, and pronation; supination rather weak.

May 17.—Discharged. Wound nearly healed; motion perfect; no contraction as yet.

July 10.—Wound perfectly healed; no contraction; perfect use of arm.

(3.)—A. F., at. 17, sawyer, was admitted on the 20th April, 1883, with wound of right arm inflicted by a circular-saw.
The wound was about four and a half inches long on the front and outer side of the right wrist, and greatly lacerated. It divided the flexor tendons, the radial vessels, and the lower end of the radius, which was sawn almost off, but the joint was not opened.

Both ends of the artery were secured and torsioned, the tendons secured and their divided ends brought together with catgut, and the edges of the wound pared and brought together with superficial sutures, a drainage tube inserted, and wound thoroughly washed with carbolic acid lotion one in forty. The bone was then placed in position on a back splint, and the hand slightly flexed; wound dressed by Lister's method.

April 23.—Has had no constitutional disturbance and no pain. Dressed; no discharge; in good position; healing by first intention.

April 25.—Tube removed.

April 27.—No pain or constitutional disturbance; wound healing; slight serous discharge; a little gaping at outer margin, where tube had been inserted.

May 4.—Wound nearly healed; rest granulating healthily; passive motion to thumb and fingers.

May 5.—Discharged.

Patient returned some weeks after. Wound healed; has perfect motion in all his fingers and wrist, and in all the tendons of the thumb, except the extensor ossis metacarpi pollicis.

Medical Society of Victoria.

ORDINARY MONTHLY MEETING.

Wednesday, July 4th, 1883.

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

Present: Dr. James, Dr. Webb, Dr. Allen, Dr. Fyffe, Dr. Balls-Headley, Dr. Griffith, Dr. F. J. Owen, Dr. Girdlestone, Dr. Jamieson, Dr. Meyer, Dr. Bennie, Dr. Moloney, Dr. A. J. R. Lewellin.

The President, Dr. E. M. James, occupied the chair.

The minutes of the last meeting were read and confirmed.
Dr. Balls-Headley then read for the author the following paper:

ON THE REMOVAL OF A LARGE CYSTIN CALCULUS BY SUPRA-PUBIC LITHOTOMY.

By John Tremearne, M.R.C.S. Eng.

This calculus, measuring 2½ inches long, 1½ inches broad, and 1 inch thick, with a circumference of over 7 inches, and a weight of 2½ oz. 54 grs., or 1254 grains, is composed of pure cystin, a form of stone not only rare, but, I believe, the largest of its kind that has ever been taken out of the bladder by operation. It was removed from Mr. James Chisholm, a Ballarat sharebroker.

The patient, a very tall, thin man, aged 47, had been troubled for several years with dyspnæa and pleurodynia (?) as well as occasional sudden stoppage of urine whilst in the act of passing it, and on some occasions very small gravel had come away, resembling this one in colour.* Eighteen months before I saw him he fractured his leg, and whilst lying on his back had no trouble whatever with the water. On rising from bed after the union of the bones he found great difficulty in micturition, and very soon the dyspnæa developed into severe spasmodic asthma. The water trouble increased, so that when he first came to see me in November last year he could not retain his urine beyond an hour, rarely that, and suffered much pain in the perineum and end of the penis. Every time previous to passing his urine he had half an hour of fearful forcing pain, and was obliged to rest on his knees and elbows until the bladder was emptied. His suffering had emaciated him, his breathing was short and difficult, and he could not walk across the room without assistance.

On November 27th, chloroform was administered by my assistant, for although the asthma was bad and the base of the left lung consolidated, it was impossible from the great sensitiveness of the urethra, &c., to examine him without it. Directly the sound entered the bladder it struck a stone. A finger was introduced into the rectum, and the stone pushed forwards, so that it could be distinctly felt by pressing the fingers of the other hand on the abdomen just above the pubes. On introducing a Lithotrite, instead of the sound, the size of the calculus was pretty accurately determined.

Three days after this examination he was again put under the influence of chloroform, and I extracted the stone successfully by

* The small gravel are sent with the stone.
the supra-pubic or high operation. A tube was then put through the wound into the bladder, and fastened by tapes with long pieces of strapping around the abdomen. The tube was a large one, so that the bladder contracted around it and prevented extravasation. At the end of a week it was removed, and on the twelfth day urine commenced to pass through the urethra.

Before the wound closed the asthma had disappeared, and within five weeks of the operation he gained thirty pounds in weight, and had apparently completely recovered his health.

In this case the large size of the tube introduced into the wound is particularly to be noticed. In the lateral operation I always adopt the same method (the vaginal pipe used with Higginson's enema apparatus answering the purpose very well), and leave the tube in the bladder usually four or five days.

In addition to preventing extravasation it is a great help in checking secondary haemorrhage, should anything of the kind occur, and renders washing out the bladder easy.

Within the last few years I have performed lithotomy eight times, and every one of my cases has recovered quickly and perfectly.

Creswick, June 1st, 1883.

Dr. Headley remarked that Dr. Tremearne laid great stress on the value of the large tube as a means of preventing extravasation. Cystin calculi were very rare; there were a few specimens in the Museum of the Royal College of Surgeons, but none, he believed, so large as the one now shown.

Dr. Allen said that the largest cystin calculus noted by Coulson was in the University College Museum, and weighed 850 grains; another at Bartholomew's weighed 740 grains. Heath once exhibited nineteen taken from a single patient. Cystin calculi are formed originally in the kidney, the nucleus being sometimes uric acid, sometimes pure cystin. Their colour on removal was usually honey yellow, becoming greenish on exposure; as a rule they were friable, and could be crushed without difficulty. With the present specimen the finger nail sufficed to make a white scratch; hence it would be interesting to know whether any attempt was made to crush it. Surely when the stone was once caught in the grasp of the lithotrite, a surgeon would be tempted to try the effect of a squeeze. Cystin is very rich in sulphur, being nearly related to the taurin of the bile. Such calculi often ran in
families, and it would be well to learn if there was any hereditary predisposition in the present case.

Dr. Girdlestone remarked that the specimen was most interesting, and perhaps Dr. Tremearne would present it to the Society or to the Medical School Museum, where it would be greatly valued on account of its size and rarity. He did not gather why the supra-pubic operation was performed; it was more dangerous than the lateral method; and as the stone measured only an inch and three-quarters in its shortest diameter, it could have been removed through the perineum. The calculus was so flat that the forceps grasping it would not have measured two inches across; hence the bilateral operation or the old rectovesical method would have sufficed. However, the case ended most successfully, although he could not understand why the particular operation was selected. Dr. Slater, of Beechworth, a very able surgeon, had sent him a card with notes and drawings of a calculus weighing 1746 grains measuring 1.65 inches in its lesser diameter, which was removed by the recto-vesical operation.

Dr. Moloney regretted that the notes of the case were not fuller, as it included many points of interest. For example, as to the occurrence of asthma, he would like to know whether, when the patient was confined to bed with a fractured leg, the dyspnoea was absent as well as the symptoms referable to the calculus. The chemical composition of the stone might give some clue to the treatment of asthma due to reflex irritation from the genito-urinary tract. The origin of asthma was sometimes very obscure; he had been much perplexed about one case in which there was great pain over the heart and distress of breathing; and it turned out to be a reminiscence of an old attack of Indian fever. As to cystin calculi, he had seen one or two, and they could be crushed with particular ease. The ultimate microscopical form was a hexagonal plate, and probably they broke up with a corresponding cleavage.

Dr. James said that prior to the operation the nature of the stone was apparently well known, and, as had previously been remarked, when once a lithotrite was made to grasp the calculus, it must have been very tempting to try and crush it. No doubt Dr. Tremearne had sufficient reasons for the operation he selected.

Dr. Balls-Headley stated that in a private communication Dr. Tremearne had informed him that he put in the lithotrite with the intention of crushing, but the utmost effect he was able
to produce was a scratching of the surface, and hence it seemed useless to attempt anything further in this way. The supra-pubic operation was adopted because large stones are so apt to prove fatal; they can be removed by the perineum, but much tearing results, and the patients are apt to die; with the supra-pubic operation laceration of tissue is avoided. Small pieces of the calculus were analysed by a Ballarat chemist, and found to be pure cystin, though very hard. It would appear as if the stone received large additions while the patient was in bed with the fractured leg. He regretted that the notes of the case were not more full.

[Dr. Tremearne has since given the following information in answer to questions:—There was no hereditary history of calculus, nor did examination of the urine indicate any affection of the kidneys. The first symptoms of stone appeared five years ago. There appeared to be no relation whatever between the vesical irritation and the asthma, and therefore Dr. Tremearne was much surprised to find the asthma disappear after the operation. It was ridiculous to think that the stone could have been crushed. A small calculus of similar nature was passed shortly before the operation; it also was extremely hard, and under pressure of a lithotrite it would not split up, but collapsed like a piece of hard wood. Before the large calculus was removed, an attempt was made to crush it with a powerful lithotrite, the handle being turned at last with a large nippers, but only the slightest mark could be produced on the surface. The stone was too large for the lateral operation, and under such circumstances he thought that the supra-pubic method should be resorted to.

Dr. Balls-Headley also read for the author the following paper:

ON THE REMOVAL OF A VERY LARGE TUMOUR OF THE BREAST.

By John Tremearne, M.R.C.S. Eng.

This is a portion of a tumour I removed a few weeks ago, with the assistance of Dr. Thornton, from the left breast of a very stout plethoric lady, the wife of a station master on the Victorian Railways. The only remarkable feature about it is its size. The total weight of the morbid growth, which was something the shape of an hour glass, amounted to twelve pounds. This is the lower half which involved the breast. The upper part extended
around the left side and into the axilla. It could only be dissected out in small pieces, which it was thought were not worth preserving. A small cyst, part of which has been cut off, marks the junction of the upper to the lower portion of the tumour. During the operation the bleeding was excessive, about twenty vessels requiring ligature. The patient made an excellent recovery, two-thirds of the wound uniting by first intention, and by the end of three weeks she was able to return to her own home. Antiseptic dressings, &c., were used.

Creswick, June 1st, 1883.

Dr. Headley then exhibited the tumour.
Dr. Allen remarked that apparently it was a soft sarcoma, with softening or cyst development. Probably it would recur.

Dr. Moloney suggested that further particulars about the case were desirable. The information given was very little. If Dr. Allen would examine the tumour, Dr. Tremearne might be asked to give the history in more detail.

It was agreed, on the motion of Dr. Jamieson, that Dr. Allen be asked to examine the tumour and report upon it; and that such report, with any further information obtainable, be appended to the published proceedings of the Society.

[Dr. Tremearne states that there was no family history of tumours, cancerous or otherwise, or of phthisis; the patient's relatives had lived long and enjoyed good health. The tumour had been noticed for only eight months before removal; but even when first seen, the whole mammary gland was involved, so that the growth probably extended over twelve months.]

[Dr. Allen reports that the tumour was a sarcoma, chiefly composed of medium-sized spindle cells.]

Exhibits by Dr. Williams.
The Hon. Secretary then exhibited for Dr. Williams the following specimens:

A case of Patent Foramen Ovale in an Adult—Death from Typhoid Fever.

M. C., a domestic servant, single, aged 28, was admitted into the Melbourne Hospital on April 30, 1883. She had been ill with intermissions for three years, suffering from pain at the epigastrium and vomiting; pain over the heart, of a stabbing character, shooting up to the left clavicle, outwards into the
axilla and backwards towards the scapula. Menstruation was irregular and the flow scanty; and she had been subject to vomiting of blood at the catamenial periods.

On admission, patient was very spare and of sallow complexion; there was a soft systolic bruit audible both at the apex and base of the heart, loudest in the area of the pulmonary artery; there was a marked difference between the radial pulses, the left being weaker both as felt by the finger and when tested by the sphygmograph. The temperature of the body was not above normal. The bowels were constipated. The other organs of the body seemed to be fairly healthy.

During the month of May, the next which followed, the patient's temperature was regularly taken; from time to time there were slight febrile attacks, lasting two or three days, the temperature ranging from 98° to 100-2° Fahr. Thus on two occasions there was a continuous rise for 36 hours from the normal line to 99-8°, and then after a short fastigium the temperature would fall with tolerable uniformity for two or three days towards the normal. For days together the body heat was little over 98°. The little febrile movements were much less marked at the end of May and the beginning of June. But during all this time the patient was becoming perceptibly weaker, and at times the pain in the chest was very severe and of a gnawing character.

On June 8, a patient was admitted into the next bed to that occupied by M. C., suffering from well-marked typhoid fever. Very shortly M. C. developed marked symptoms, headache, fever, loss of appetite, and then pain across the upper part of the abdomen; on the 16th her temperature reached 105° Fahr., and on the 17th 105-2°; the tongue was now moist and coated, great thirst, flushed face, delirium at night, severe pain in the chest, but no dulness, the lung sounds continuing clear. Diarrhoea set in, and the abdomen became distended and tympanitic. After a decided fall of temperature on the 17th, the body-heat again rose to 105° on the 19th, falling rapidly again on the following days. The fever continued remittent, but of a very irregular type, the temperature repeatedly falling below normal, and death took place from exhaustion on the 27th.

At the autopsy, twenty-eight hours after death, the body was found much wasted, the face sallow, not at all cyanotic. The heart was small, the left ventricle feebly contracted, the right cavities full of thin dark fluid blood, mingled with pale gelatinous
clot. The foramen ovale was widely patent, with no tendency to valvular closure, an oval aperture existing between the auricles, \( \frac{3}{4} \) of an inch in length from above downwards, and fully \( \frac{1}{4} \) of an inch broad, the edges of the opening being thin and smooth. The tricuspid orifice admitted four fingers, the segments of the valve being large, thin, and transparent. The pulmonary artery and valves were normal, the ductus arteriosus obliterated. The mitral valve admitted the tips of two fingers; it was free from vegetations; the right extremity of the anterior segment was puckered. The walls of the left ventricle were thin; the aortic valves and coronary arteries healthy. The arch of the aorta was quite healthy, except in the third portion, where some slight opaque transverse streaks of atheroma were noted on the inner surface of the vessel, and a small area of bluish inelastic thinning; the outer coat was not affected, nor was the vessel bound down to any adjacent structures, and the descending aorta was perfectly normal.

The lungs were congested posteriorly, emphysematous anteriorly.

The liver was congested, weighing 38 ounces; the substance was rather friable; the centres of the lobules were deep pink, while the margins were yellow.

The spleen was congested and friable, weighing 5\( \frac{3}{4} \) ounces.

The kidneys weighed four ounces each; the capsules peeled easily; surface smooth; cortex opaque and streaky; substance rather friable.

In the small intestines, the lower five and a half feet of the ileum presented decided lesions. In the upper part of this tract, Peyer’s patches were slightly swollen, purplish, and pitted; lower down were four patches in quick succession, much swollen and congested, with raised edges, which floated upwards with water, and filamentous or smooth slightly excavated bases. Still lower, Peyer’s patches presented large shallow ulcers, with purplish filamentous bases, which as a rule involved only the mucous and perhaps part of the submucous coats; the edges were partly free, usually pale, sometimes slightly pigmented; not far from the valve, in the centre of one of these ulcers, a small deep excavation ran down to the subserous coat, which remained pale, without any trace of thickening or granularity. Still closer to the valve one very superficial ulcer appeared to be imperfectly healed; and the surface of the valve itself was thickened and congested with
patchy pigmentation. The solitary glands in the lower part of the ileum and in the colon were decidedly swollen.

Mesenteric glands swollen, dark purple and friable. There was a thin but wide extravasation of blood beneath the peritoneum, close to the lower end of the ileum.

The stomach was slightly congested.

The os uteri was patulous, its lips being swollen and congested.

The spine was free from erosion, thickening, or traces of any inflammatory process, although there was slight irregularity in the line of spinous processes in the lower dorsal region.

For the clinical history, Dr. Williams expresses his indebtedness to Dr. Moore, and for the pathological description, to Professor Allen.

Exhibits by Dr. Allen.

Dr. Allen then exhibited the following pathological specimens:

I.—Caries of Spine; Abscess behind Descending Aorta.

The anterior surfaces of the bodies of the dorsal vertebrae from the third downwards are deeply eroded; the intervertebral cartilages are largely destroyed, leaving patent fissures between the bodies; the costovertebral articulations are in many cases laid open, the heads of the ribs being rough and carious. The descending aorta, with the adjacent layers of pleura, was separated far from the spine, the intervening space forming a large abscess cavity, with opaque, yellowish-white granular walls, and containing thick curdy pus. The aorta was closely bound to the abscess wall, but its calibre was not affected, and its inner coats were perfectly healthy. The pus had burrowed backwards and downwards on the right side of the spine between the eleventh and twelfth ribs, among the muscles of the back, to open just above the crest of the ilium. The dorsal spinal nerves were more or less laid bare in the posterior wall of the abscess, their sheaths being covered with coarsely granular yellowish-grey exudation. There was only the slightest backward projection of the middle dorsal spines.

The body was extremely emaciated; the feet and scrotum oedematous. The left pleural cavity contained a large quantity of blood stained pus, which had escaped from a small rupture in the lower part of the wall of the great abscess; but the fluid was limited by the presence of scattered old adhesions, and more recent false membranes. The left lung was everywhere bound to the
chest wall. Both lungs were semi-solid, the left base breaking down into pus.

The *bronchial glands* were enlarged, and contained nodules of cheesy matter.

The *spleen* was moderately amyloid, the Malpighian bodies being swollen, grey, and translucent, and giving the characteristic reaction with iodine.

The *liver* was large and very friable, with patches of advanced fatty charge.

The *kidneys* had slightly adherent capsules; the cortices were streaky; but both liver and kidneys were free from amyloid infiltration.

The patient, J. B., a strumous boy, aged 14, was admitted under the care of Mr. James, on January 26th, 1883. Eighteen months before, he first noticed pain over the crest of the right ilium; subsequently, about three months before admission, a hard lump formed in the same situation, and, gradually softening, was ultimately opened. At this time there was no curvature of the spine, and no pain on pressure over any part of it. There was a free discharge of pus from the opening, at first thin, but afterwards becoming thicker and more and more profuse. A probe could be passed inwards and upwards nearly as far as the spinal column, but no dead bone could be felt. There was always considerable difficulty in breathing, with marked consolidation of the base of the left lung. The patient could not retain one posture for any length of time, and seemed most distressed when sitting up, being then almost unable to breathe. He gradually became exhausted, and died on July 3rd.

The clinical notes have been kindly furnished by Dr. F. J. Owen, the house surgeon.

**II.—Recto-urethral Fistula; Tubercular Bladder.**

In the anterior wall of the rectum is a large irregular ulcer, the base of which is closely bound to the prostate and floor of the bladder; and there is a distinct perforation in the floor of the ulcer opening into the front part of the prostatic portion of the urethra. The tissues of the prostate are much indurated, infiltrated with cheesy matter, and channelled with suppurating sinuses. The bladder is hypertrophied, the muscular coat being much thickened; the mucous membrane is irregularly swollen, nodular, slightly sauculated, with irregular ulcers and a general...
granular condition of surface; the miliary granules were originally very distinct, but have faded somewhat since the specimen was placed in spirit.

The specimen was obtained from J. W., a porter aged 63, who was admitted under the care of Dr. Fulton, on June 2nd, 1883. He had been suffering from rheumatic gout for many years, the fingers being much distorted; but about six months ago there was great pain in the lower part of the abdomen, and at last something was felt to give way there. Subsequently he had constant diarrhoea, and says he passes faeces per urethram. There had been pain and tenderness in the lumbar region, especially on the right side; and also oedema of the ankles spreading up the legs, especially the left.

On admission the patient was emaciated and tremulous, the left leg being oedematous; the urine turbid, alkaline, containing one-fourth of albumen; absence of breath sounds, coarse râles and increased vocal resonance in the right infraclavicular region. Respiratory murmur inaudible over the right base posteriorly. Death ensued eight days after admission.

At the autopsy the body was found much emaciated; the bones of the hands were clubbed and distorted with old arthritis deformans; there were purpuric patches on the right wrist; both legs were oedematous, especially the left.

The pericardium contained about seven ounces of clear straw-coloured fluid; the heart was thin-walled and flabby, weighing eight ounces; the tricuspid valve admitted four fingers; the other valves were normal.

There were universal old adhesions over the right lung; the upper lobe was puckered and scarred, pigmented and airless, and on section contained remnants of old cheesy nodules, one of the bronchial tubes being dilated into a cavity of considerable size; at the base there was a large yellow cheesy patch, softening down at its upper part. In addition, both lungs contained numerous small cavities, some full of soft cheesy matter, and scattered through their substance were great numbers of greyish hard miliary tubercles, sometimes isolated, sometimes forming distinct groups. The extreme anterior borders were emphysematous, while the dependent parts were gorged with frothy blood-stained fluid, and friable.

The liver was friable, weighing 58 ounces; the centres of the lobules deep pink, the borders pale and yellowish grey.
The spleen weighed 10 ounces; the cut surface was distinctly sago-grained, from amyloid deposit in the Malpighian bodies.

The kidneys weighed 12 ounces; their surfaces were puckered from patchy atrophy. The capsules were adherent, the stellate veins well marked; the mucous membrane of the pelves swollen and congested.

In the intestines, besides irregular ulcers in the rectum, there were tuberculiferous ulcers scattered through the lower five feet of the ileum. The ulcers occupied Peyer's patches, and spread transversely; their edges were thickened, slightly raised, irregular, and pigmented; the bases were thickened, opaque, and granular; the peritoneal surface opposite was congested, and dotted here and there with miliary tubercles.

The left iliac veins were plugged with pale adherent clot, softened at its centre; the clot extended upwards as a free conical wave-marked process into the inferior vena cava, partly obstructing the orifice of the right common iliac vein.

III.—Typhoid Fever; Limited but Deep Ulceration; Bronchopneumonia.

P. C., a blacksmith, aged 45, was admitted under the care of Dr. Robertson, on June 14, 1883; he said he had been ill five days, with shivering, giddiness, pain in the head, thirst, and loss of appetite. On admission, the temperature was 102°, the pulse 108; the respirations 20. There were no spots, no distension nor tenderness of the abdomen, and no diarrhoea.

June 19.—Tongue dry and coated; bowels open; very deaf. Temperature preceding evening 101.2°; morning 98.4°; pulse 114, compressible; respirations 24.

June 24.—Abdomen distended and tympanitic; no pain; bowels slightly relaxed; is very deaf; pupils contracted. Skin covered with cold clammy sweat. Temperature, preceding evening 99.4°; morning 98.4°; pulse soft, 102; respirations 24.

June 25.—Tongue dry and brown; sordes on lips and teeth; severe diarrhoea; blister forming over sacrum.

June 27.—Tongue dry, brown, and tremulous; delirious; pulse 114, very feeble; diarrhoea stopped.

June 28.—Temperature preceding evening 100.4°; morning 98.4°; pulse 126, soft and feeble; respirations 30.

July 1.—Pulse 144, very weak; respirations 36. Picking at bedclothes; any part pressed on sloughs.
July 2.—Died.

At the autopsy, the muscles were found very dark; the heart, everywhere relaxed; scattered through both lungs were small pinkish-red, indistinctly granular patches of consolidation (lobular pneumonia), the intervening tissues being congested and friable.

The spleen was moderately enlarged.

The liver congested and friable.

The kidneys pale, friable, with opaque, streaky cortices.

The mesenteric glands were swollen, purple, and friable.

The lower four-and-a-half feet of the ileum displayed the lesions of typhoid fever. Above, Peyers patches were slightly swollen and pitted; lower down they contained pale ulcers, with thin, free edges and pale bases, sometimes exposing the circular muscular fibres. In most cases the ulcers occupied only part of a patch, being small but deep. Near the valve the edges were pigmented.

The following is the complete temperature chart:

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<th>Evening</th>
<th>Pulse</th>
<th>Respiration</th>
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<td>&quot; 30</td>
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<td>P. 144</td>
<td>R. 36</td>
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<td>102.6</td>
<td>Died</td>
<td>Twenty-third day of disease</td>
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</table>

For the clinical history Dr. Allen expresses his acknowledgment to Dr. Moore.

IV.—Hypertrophy of Liver and Spleen.

Dr. Allen also exhibited specimens of enormously hypertrophied liver and spleen, the former weighing 172 ounces, the latter 176 ounces. The consistence of the liver was about normal, but the
spleen was dark and very firm, with patchy thickening of the capsule. The kidneys weighed 16 ounces; they were large and flabby, capsules slightly adherent, surface smooth, cortex broad. The heart weighed 12 ounces, and was flabby, everywhere relaxed. All the cavities contained soft yellow opaque clot, resembling concreted pus. Similar clot was found in the pulmonary vessels. The lungs were intensely emphysematous; the dependent parts somewhat congested and friable.

The patient, G. R., aged 25, was admitted under the care of Dr. Robertson, on June 16th, 1883. Fifteen months previously he first noticed enlargement between the ribs of the left side, which gradually increased, reaching its present size in about five months, and then remaining stationary. During the last fortnight before admission he noticed a dull pain over the tumour, with a sensation of great weight in the abdomen. At present he is of sallow complexion, and complains of weakness and shortness of breath. The appetite is good; the bowels regular; there is no dropsy; the temperature is normal; the sounds of the heart and lungs healthy.

The patient has always lived in this colony, except for occasional trips during shearing time twenty miles over the border into South Australia. He has lived on ordinary food—meat, vegetables, &c.; and had never suffered from malaria, syphilis, or other serious disease.

A few days after admission he suffered from severe headache and bleeding from the gums. On the evening of the 27th he had epistaxis. On the following morning his temperature was 105°, and he died suddenly at 10 o'clock p.m., twelve days after admission.

Dr. Moore, the resident physician, has kindly furnished the few clinical notes available.

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Australian Medical Journal.

JULY 1883.

QUARANTINE.

The subject of quarantine is one which has a very special interest at the present time. Its advantages and disadvantages have lately been warmly discussed in nearly every civilised country, and very curious differences of
opinion have been found still to exist, after centuries of experience. In these Colonies, up till quite recently, the problem has been a comparatively simple one, and it by no means follows that the practice adopted, voluntarily or under pressure of circumstances, in the mother country, is necessarily the most desirable here. In Great Britain, of late years, there have been developed among sanitary authorities what look like quite contradictory tendencies with regard to it. What has been called "external quarantine," is systematically cried down, as both cruel and inefficient; while "internal quarantine" has been coming into favour in almost equal measure. By the former, of course, is meant quarantine in the popular sense of the word—the compulsory isolation of all persons arriving from some suspected port by sea, and especially when any of them during the voyage had showed symptoms of the disease whose introduction was feared. That practice, in its full extent and severity, has long been abandoned in England. To carry it out, as was done a century or more ago, would have involved such disturbance of trade and other relations with foreign countries, that the attempt had to be given up; and there was the less reason for trying to continue it, inasmuch as most epidemics likely to flourish are already thoroughly acclimatised. The endeavours made to keep out cholera in 1848 failed so utterly, that the system became completely discredited; and there seems now to be almost perfect unanimity of opinion among English sanitarians, that the only means of opposing that disease efficiently is by general sanitary measures. Nothing can be more gratifying to the cultivators of scientific hygiene, than the absence of panic among the English public, in the face of the imminent danger of a fresh inroad of Asiatic cholera, and the confidence shown in the means which have been adopted for improving the sanitary condition of all parts of the country, and especially the large towns.

In these Colonies we are rather differently situated. Even now, in these days of short voyages, we are far enough from the great centres of population to allow of almost any contagious disease developing itself between the ports of
arrival and departure. And further, the number of foreign arrivals is comparatively limited, so that the difficulties attendant on isolation and supervision are in a manner slight. It is true that we have not succeeded in keeping out measles, scarlatina, typhoid, and some other epidemic diseases; but we seem to have kept out small-pox, or, at least, have prevented it from spreading widely; and cholera has never found its way to our shores. It is also certain, that small-pox has more than once gained admittance, in spite of our port regulations, administered almost to the extent of cruelty in some instances; and our immunity from cholera, so far, is most probably owing to the small amount of direct intercourse with the countries where it has raged, at previous periods when it put on the pandemic character. The victories gained by the adoption of quarantine regulations, therefore, in these Colonies, have often been at best doubtful.

With regard to internal quarantine, or the adoption of measures of isolation, disinfection, &c., to limit or stop the spread of infectious diseases, after they have been introduced into a particular locality, the experience has been rather different. Of course, the system of cordon, which has been tried recently in Egypt without success, is not likely to be adopted in any English-speaking community. But it has been abundantly proved that, by early isolation and careful supervision of first cases, aided of course by the adoption of proper hygienic precautions, the general diffusion of an epidemic disease in a particular town or district may often be prevented. Both in New South Wales and Victoria success has followed measures adopted for stamping out small-pox which had been accidentally introduced. Sanitarians of the more ardent sort even express the hope that, in the better and wiser days to come, all epidemic diseases will, one after another, be stamped out; and if such hopes lead to efforts for their attainment, they may well be cherished.

The success which has attended the system of internal quarantine, just defined, has of course been denied, and its advocates derided by that rather crotchety organ of opinion, the London Spectator; but it is none the less real, and ought to serve as a guide in the steps adopted for preventing the
introductory introduction of diseases from abroad. Sweeping quarantine regulations, in the old sense, are not thought of now in England; but it does not follow on that account that no precautions are to be taken. According to the regulations issued by the Local Government Board, all ships arriving from cholera ports are to be inspected by competent medical examiners, and, if no cases of disease are discovered, there is no further detention or interference. If any cases are found, the patients are to be cared for on shore, the healthy persons being dismissed, after disinfection of the ship and all suspicious articles has been affected. The only further interference with the freedom of healthy passengers proposed is, that they are to leave their names and their intended destination with the port authorities.

Different from these have been the rather wild proposals we have lately had from our authorities, to enforce strict quarantine precautions against all ships, from ports of every name, from Fiji to Suez. It would be far better to adopt, and carry out thoroughly a system of inspection by a competent medical man of all ships coming from foreign parts; more careful attention being given to those coming from places known to be infected. There has been great want of persistent care in this respect; periods of laxity alternating with others of unnecessary strictness, as the mood of saving or of profusion happened to seize the head of the department for the time being. If this inspection were properly and consistently done, the loss of time, money, and temper involved in sending ships to the quarantine ground might be avoided in most cases; and only a short detention for disinfection, &c., need be adopted in any case. The proposal to have some uniform method followed at the ports of the different Colonies is a right one, and, if adopted, will affect much saving without appreciable increase of risk. This subject may with advantage be discussed at the coming Intercolonial Conference; and if advice and suggestion be taken from the best available authorities in the medical profession, a way of getting over difficulties might be devised. To look for, or follow the counsel of members of our profession, even on their own ground, is not enough the
custom with some of the Victorian men in power; but it is certain that only by obtaining such assistance can proper methods be devised or carried out.

**DR. WILKINS AND THE MOORFIELDS HOSPITAL.**

In our number for January last we extracted from the *Evening Star*, of Dunedin, a public notice issued by the New Zealand Medical Association to the effect that Dr. Wilkins was falsely advertising himself as “late of the surgical staff Royal Eye Hospital, Moorfields, London;” whereas the Secretary of that Institution officially declared that “no Dr. Wilkins was ever at, or for any time on the staff of this Hospital.”

Dr. Wilkins has favoured us with copies of documents which prove incontestably that he was appointed Clinical Assistant to the Moorfields staff in 1866; this fact is attested both by the Senior Surgeon, Mr. Bowman, and by the Secretary, whose first mis-statement gave occasion to our extract. We greatly regret having shared in spreading a false report to the detriment of a well-known practitioner.

**Obituary.**

**MR. WILLIAM THOMSON, F.R.C.S. Ed.**

In our last number we could but barely notice the death of Mr. William Thomson, who for the last ten years has played such a conspicuous part in Victorian medical literature. Mr. Thomson was born at Paisley, in 1819. He received his medical education at the Glasgow University and the Andersonian School of Medicine, and in 1843 became a Licentiate of the Royal College of Surgeons, Edinburgh. Nearly ten years later, very shortly after the discovery of gold in Victoria, Mr. Thomson first came to the colony in charge of an immigrant vessel; and he made five subsequent trips in the same capacity before finally settling down, in 1854, to practise in Melbourne. His industry and ability soon made him prominent in the ranks of the profession. For some time he was librarian to the Medical Society of Victoria, and from 1859 to 1861 he acted as editor of this journal; but unpleasantness.
arose, leading to the severance of his connection both with the Society and the journal. Thenceforward he was not on friendly terms with a large section of the profession, an unfortunate fact, which greatly militated against his influence in our local medical world; but he was not on that account less prominent before the public. Numerous books and pamphlets, and still more numerous communications to the daily press, issued from his fluent pen; but every publication, though bearing marks of great industry and keen thinking, seemed to entangle him in fresh controversies, generally conducted in no gentle spirit; and in the heat of argument which he provoked his opponents were somewhat apt to forget the unquestionable value of his work. He had not perhaps any strongly-developed judicial faculty, but possessed all the ardour and rhetorical power of a skilled advocate; yet, however that might be, he brought important medical questions before the public in a vigorous style which could not fail to attract notice, and thus rendered decided service to the community.

Mr. Thomson's first important work was published in 1870, and dealt with the prevalence of phthisis, and the alleged prophylactic and curative influence of Australian climates. Subsequent pamphlets on the same subject embodied the results of his further inquiries ending in 1879. He pointed out that the deaths from phthisis among the Victorian born, as compared with all deaths from phthisis in the colony, had risen from 9·63 per cent. in 1871 to 18·11 per cent. in 1877; and, from Mr. Hayter's more recent statistics, we find that the percentage in 1881 was 28·10. Again, Mr. Thomson wrote as follows:—"It will be seen that out of the 3003 of whom particulars could be obtained who died of phthisis in Victoria during 1876, 1877, and 1878, 762, or 25·37 per cent., were born in Australasia; that 2003, or 66·70 per cent. more, had resided there for upwards of five years; that 112, or a further 3·73 per cent., had lived there for upwards of two years; and that only 126, or about 4 per cent., had lived there for less than two years." Again, he could urge that, during 1877, 12·8 per cent. of all deaths in Victoria, and 23·10 per cent. of all deaths in Melbourne, were due to phthisis. A sub-committee of the Medical Society, dealing with the same subject, came to almost diametrically opposite conclusions, and their report may be found in the number of this journal for December, 1877. Probably the correct opinion was that pronounced by the earliest writer on the subject, Dr. Bird, in his
A brochure published in 1863:—"In short, there is no mystery about the matter. We need call in no . . . specific agency in the Australasian air to account for our low mortality from consumption. The simple reason is that here the plain ordinary elements of health—air, oxygen, light, exercise, nourishing food—have more opportunity of exhibiting their normal operation on masses of the population than they have in England."

Closely related to the same subject was a pamphlet on "The Histo-chemistry and Pathogeny of Tubercle," published in 1876. The modern doctrines concerning the structure of tubercle were then fairly complete. The existence of giant cells amidst a lymphoid tissue was recognised by most original observers. The presence of peculiar granular bodies had been noted, and it had been questioned whether or not they were true micrococci. The infective power of tubercle within the body was well known, and even the most common students' text book of pathology said it was possible that this power in products apparently inflammatory might possibly "be determined by atmospheric influence, or by the presence of minute organisms." Villemin, Klebs, Waldenburg, Wilson Fox, and others, had shown that when animals were inoculated with tuberculous matter they developed a disease which these observers considered identical with human tuberculosis. Dr. William Budd had allied tuberculosis causatively to the acute specific fevers. Mr. Thomson, reasoning from these facts, argued that the granular bodies noticed in tubercle must be true microzymes, and the true exciting or proximate cause of the disease. He described these germs as withdrawing nitrogen from nascent epithelial cells, the blighted cells accumulating in the air vesicles as a nodular mass, and the microzymes remaining "buried as it were in the ruins they produced." "The action thus set up by micrococci would constitute tuberculosis a true mycosis. . . . If the explanation here offered be found true, it will fully account for the febrile symptoms occurring on every fresh swarming or multiple of the parasites; also for the consecutive anatomical lesions in the trabeculae, inter-alveolar growths," &c. Mr. Thomson further brought this germ theory into relation with the doctrines of caseation of Buhl, Niemeyer, and others in the following way: "While the caseous centre remains encapsuled, the external air is excluded; but a breach in it, caused by ulcerative absorption, allows access by the germs of micrococci. . . . These germs, by developing and multiplying, naturally migrate through the
afferent channels of the lymphatics to the lymphatic glands. . . . There the parasites will operate, . . . the resulting morbid products being of precisely the same nature. . . . If, on the other hand, the micrococci be taken up by the venous radicals, they will equally readily be conveyed thence through the capillaries of the pulmonary artery, and thus finally reach the alveolar walls of the air vesicles, where they will operate again upon the freshly exuded protoplasm. . . . By their nature these plastid particles of hyaline will possess the power of amœboid movement."

It was not till March 24th, 1882, that Dr. Robert Koch, at a meeting of the Berlin Physiological Society, described the bacilli which have now become famous. These bacilli probably differ altogether from the granular bodies referred to by Mr. Thomson, and it is still uncertain what rôle they play in the tubercular process. But, so far as we know, Mr. Thomson was the first, not merely to maintain without limitation that phthisis was a contagious disease caused by germs, but to attempt a coherent explanation of the phenomena of phthisis in accordance with this theory.

In 1874 Mr. Thomson was invited by the Central Board of Health to inquire into the causes which led to the unusual prevalence of typhoid fever during the preceding autumn. At that time the most varied titles were given to the endemic fever of this colony, as for example—typhoid, typhus, continued fever, gastric fever, enteric fever, colonial fever, low fever, relapsing fever, bilious fever, &c.; all these names then figured among the causes of death set forth in official certificates, and no little uncertainty seemed to prevail among both the public and a large section of the profession concerning the true nature of the disease. At the leading Hospitals it was fully recognized that there was only one form of fatal continued fever known in the colony, namely typhoid or enteric fever; and the Lecturer on Medicine at the University, Dr. James Robertson, had for about ten years been teaching that according to the weight of authority this fever never arises de novo, but always spreads from the sick to the healthy, the specific poison being contained in the stools of the patients. These were the doctrines of William Budd, of Bristol, first enunciated by him in the Lancet for Nov. 15th, 1856.

In 1873, Dr. Budd published his masterly work on Typhoid Fever, its nature, mode of spreading, and prevention; and by the history of the North Tawton and other outbreaks, he clearly
brought typhoid within the group of specific contagious fevers, and showed that it did spread from person to person, and from village to village; and last, but not least, he drew up a set of rules for popular use, whereby through due attention to disinfectant measures the diffusion of the disease might be prevented.

However, in the same year, Dr. Murchison, in his great work on the continued fevers, after a lengthy argument, stated that typhoid fever "may be generated independently of a previous case by fermentation of faecal, and perhaps other forms of organic matter. It may be communicated by the sick to persons in health, but even then the poison is not, like that of small-pox, given off from the body in a virulent form, but is developed by the decomposition of the excreta after their discharge." In many standard text-books the doctrine of contagion was treated as a doubtful matter, or even gently laughed at.

Under such circumstances Mr. Thomson commenced his inquiry; he espoused with the greatest ardour the doctrines of Budd; he referred to the experience of our hospitals as convincing proof that we had to deal with typhoid, and typhoid only; and by analyses of statistics and by histories of particular outbreaks, he endeavoured to show that contagion was the one law which governed the prevalence of the fever. This view, though advocated with very great ability, did not commend itself to the Central Board, and Mr. Thomson was forced to publish his report on his own behalf. He repeatedly returned to the same subject, the third and last edition appearing in 1878. Mr. Thomson now contended that the varying prevalence of typhoid in the colony had been governed by the degree in which disinfectant treatment had been pursued. His earnest and untiring advocacy of the contagion theory has without doubt been of decided service to the public, and has greatly hastened the spread of more correct opinions among the profession; and if lazy Boards of Health and ignorant municipal bodies took advantage of these views to save themselves the trouble of attention to ordinary sanitary measures, that evil cannot fairly be laid, as it has been, at Mr. Thomson’s door. His own words are as follows: "A purely contagious theory of typhoid fever causation neither implies nor involves carelessness about dirt and disease. Dirt creates disease in many ways, although it is neutral about one particular mode; and dirt engendered diseases are often deeper, more deadly and enduring, with worse remote consequences, than
even the fatal out-spoken fever." It may be regretted that Mr. Thomson did not bend his acute mind to a fuller study of the conditions which favour or check the activity of the typhoid virus—a field in which so much remains to be done. But perhaps, had he done so, he would have clouded his main issue that the disease is due to germs and can be prevented by appropriate disinfectant measures, a doctrine which all recent experience has only served to confirm.

Space will not allow us to follow Mr. Thomson in his other works; he always took a lively interest in the prevention of the various cattle plagues, and thus again placed the colony in his debt. In 1871 he was elected a Fellow of his College; and for many years he was a member of the Medical Board of Victoria. He devoted much attention to the Bacon-Shakespeare controversy, warmly espousing the title of Lord Bacon to the authorship of our great national dramas; but despite all the learning and ingenuity which he brought to the defence of his pet theory, the public would none of it. For many years Mr. Thomson was deeply engaged in an extremely large practice; his views on the contagious nature of phthisis and the influence of antiseptics attracted to him great numbers of consumptives, and cases of chest disease generally; and it was matter for wonder how he found time for his varied literary undertakings.

It will thus be seen that we regard Mr. Thomson's works as having been of most signal benefit to the community; and we deeply regret that a vein of acrimony and ego-ism which frequently intruded itself into his writings alienated during his lifetime many who might have been his co-workers. But none the less earnest is the general tribute to his memory, as a man of great talents, wide culture, immense industry, who laboured untiringly for the public welfare. His death took place at his residence "Garnock," South Yarra, on May 22nd, in the 64th year of his age.

LIST OF WORKS PUBLISHED BY MR. THOMSON.

"On Typhoid Fever in Melbourne," 1874.
"A Third Analysis of the Statistics of Phthisis in Victoria—completing the series—to which are prefixed Remarks on one of the Modern Modes of Medical Treatment," 1876.
"Etiology of Typhoid Fever," 1878.
"On Phthisis and the Supposed Influence of Climate—being an analysis of statistics of Consumption in this part of Australia—with remarks on the increase of that disease in Melbourne," 1879.
"On Renascence Drama, or History made Visible," 1880.
"The Political Allegories in the Renascence Drama of Francis Bacon," 1882.
"Bacon and Shakespeare, on Vivisection," 1881.
"Ship Yachts and Full-Power Steamers," being a letter to the President of the Melbourne Chamber of Commerce, 15th December, 1872.

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**Review.**

*Systematic Census of Australian Plants: Part I. Vasculares.*


This work supplies another proof, if proof were needed, of the extensive erudition and unwearied industry of Baron von Mueller, who has made the study of the Australian flora his life's work. Of its value to students of that flora, and even to botanists generally, there can be no doubt; and there can also be no doubt that it was needed. The great "Flora Australiensis," begun by Mr. Bentham, but carried on very largely by the assistance of Baron von Mueller, contains descriptions in proper order of most of the known plants of this continent; but, since its publication was commenced in 1863, many new species have been discovered and described which could not find a place in that work. Supplements will be needed, but they would involve much labour in preparation, and some delay would of course bring with it the
advantage of allowing of completeness, no small matter in a book which is not likely soon to run to a second edition. The object of the present work is to supply full and exact references to all publications, in which are to be found descriptions of plants whether given in the "Flora" or not. Most of them are to be found in the "Fragmenta Phytothographie," the volumes of which themselves needed some such systematic index. But this work is much more than a mere index to the "Flora" and the "Fragmenta," since it supplies references also to the first published descriptions, with dates and names. It is therefore in a manner a history of Australian descriptive botany. And even with this its interest and value are not ended; since, by the addition of notes showing when and by whom the various genera, natural orders and other divisions were set up, it also becomes to a certain extent a history of botanical classification in its present form. If Baron von Mueller had been able to carry out his wish of adding to the Australian habitats references to localities in other parts of the world where certain species also occur, the interest of the work would have been considerably increased, as it would thereby have become also an essay on the geographical distribution of plants found in Australia. Such additions perhaps would have been beyond the scope of the Census, and would have necessitated an increased size of page, with, of course, considerable increase also of labour and expense. For the work as it stands gratitude is due to the learned author, and if space did not fail many points of interest might have been mentioned, suggested by a review of its pages. It is to be earnestly hoped that such encouragement and assistance may be given to Baron von Mueller, that he will be able to issue the second part, containing similar lists of the Australian "Evasculares" at as early a date as possible.

J. J.

Extracts from the Medical Journals.

THE LANCET.

Plumbism.

Dr. Porter of Sheffield, in referring to the relative frequency of the special symptoms of lead-poisoning, stated that among thirty cases colic had occurred in twenty-seven, some loss of power or paralysis in eighteen, and eclampsia in two. The characteristic blue line was present in twenty. He believed that lead palsy
only occurred after long exposure to the poison. As to pathology, he stated that it was doubtful whether the palsy was due to an anterior polio-myelitis, or whether it was to be regarded as a general peripheral neuritis. He dwelt strongly on the importance of preventive measures being adopted among those who were unavoidably exposed to the action of lead.

Chlorosis and Pyrexia.

Although much irregular fever has been detected in cases of so-called progressive or pernicious anaemia, the temperature of the ordinary cases of chlorosis met with in young women is usually believed to be normal. This belief has been contested by M. Molière in a recent number of the Lyon Médicale. His observations were made on eight young women who presented no other signs of disease beyond the anaemia for which they were under treatment. The temperature was taken every morning and evening over a period varying from two to fifty days, and was found to oscillate between 101.8° F. and 102.8° F. The amount of urea eliminated per diem was estimated and found to be normal.

Perforating Ulcers of Both Feet.

A case of the above, reported by Mr. Frederic Heath, contains a report of the microscopical appearances of the nervous lesions. The posterior tibial nerves were examined. There was a great increase of the connective tissue, especially the peri and epineurium. The lymph spaces surrounding each nerve bundle in the trunk were much expanded.

The chief points in which the case differs from those previously reported are—(1.) There was no anæsthesia of the affected limbs, but on the contrary, in the case of the left leg at least, hyper-sensitiveness. (2.) There was no profuse or foetid sweating in the left leg or foot, although this was occasionally found in the right. (3.) There was no diminution of tendon reflexes.

The Micrococcus of Gonorrhœa.

Dr. Sternberg of Philadelphia, U.S.A., has continued his observations on this subject. He finds that the micrococcus is continually present in gonorrhœal pus; it has in all cases the same morphological appearances, and no other organisms than it develop in culture fluids inoculated with this pus. His experiments agree with many other facts adduced against the
specific nature of gonorrhoea, and they show the need of caution against accepting the discovery of the presence of a micrococcus in a morbid discharge as proof of the rôle played by the organism in the causation of the disease.

**On a Method of Controlling Haemorrhage in Amputation at, or Excision of, the Hip-joint.**—Mr. Jordan Lloyd, in a paper read before the Midland Medical Society, describes his method for the above. It consists in first emptying the affected limb of blood by elevation. A strip of black indiarubber bandage, about two yards long, is to be doubled, and passed between the thighs, its centre lying between the tuber ischii of the side to be operated on and the anus. A common calico thigh roller must next be laid lengthways over the external iliac artery. The ends of the rubber are now to be firmly and steadily drawn in a direction upwards and outwards, one in front, and one behind, to a point above the centre of the iliac crest of the same side. They must be pulled tight enough to check pulsation in the femoral artery. The front part of the band passing across the compress occludes the external iliac, and runs parallel to and above Poupart's ligament. The back half of the band runs across the great sacrosciatic notch, and by compressing the vessels passing through it, prevents bleeding from the branches of the internal iliac artery. The ends of the bandage thus tightened must be held by the hand of an assistant, placed just above the centre of the iliac crest, the back of the hand being against the surface of the patient's body. It is a good plan to pass the elastic over a slip of wood held in the palm of the hand, so as to diminish the pain attending the prolonged pressure of the rubber bandage. The solid rubber tourniquet may be used instead of this bandage. He prefers, however, the bandage. The soft parts are less damaged by reason of its greater breadth, and it is less likely to roll off the compress placed over the external iliac. The ligature being altogether above the limb, is out of the way of the surgeon in any operation at or about the hip-joint. The great trochanter is fully exposed, the hip being free upwards as far as the iliac crest, and inwards to the perineum. The plan is equally applicable in amputation by transfixion, or in excision of the joint.

**On Three Successful Cases of Nephrectomy.**—Mr. Knowsley Thornton, in commenting on these cases, states that they seem to demonstrate the advantage of the lateral over the median incision;
the perfect suitability of the abdominal operation to all cases in which nephrectomy, and not mere nephrotomy, is the end aimed at; the capability of the peritoneum to dispose of large quantities of effused fluid under aseptic conditions, without the aid of the drainage tube, and without serious constitutional disturbance arising from the absorption of the effused fluids, even after the removal of such an important eliminator as the kidney. The great differences in the ages of the patients, seven, twenty-six, and fifty-eight, and the varying diseases for which the operations were performed, make the records of especial value. "The operation of Langenbach, with the extra-peritoneal treatment of the bladder end of the ureter, seems so surgically perfect, that I cannot conceive any case presenting itself in which I should care in the future to face the difficulties and uncertainties of the loin incision."

Iodoform.—Mr. A. F. M'Gill believes that iodoform may be applied with advantage in four different classes of cases:—(1.) In old septic wounds, the result of inflammation or of traumatism. (2.) In recent wounds, in the infliction of which it is impossible for the surgeon to adopt full antiseptic precautions. (3.) In wounds near any of the natural orifices of the body. (4.) As an external application combined with other antiseptic dressings.

Catarrhal Deafness in Children.—Mr. Field read some notes on this subject to the Harveian Society of London. Catarrh of the middle ear is the commonest and most important cause on account of its sequels; its early arrest is of the highest moment. It may be self-curative, but the popular plan of leaving it to itself is unsafe. For its cure one has to abolish the fons et origo mali, catarrh of the naso-pharynx. The first effects of the latter disease are swelling and blockage of the Eustachian tubes, and consequent deafness from rarefaction of the air in the tympanum. Thickening of the membrana tympani, clogging of the tympanic cavity, and interference with the movements of the ossicles are among its ultimate serious effects, and autophony and noises caused by the mucus in the tympanum may occur as symptoms. Chief among the means of treatment is Politzer's air-bag. The use of this bag, as also of Valsalva's method of ventilating the tympanum, may be rendered more than futile by a too frequent employment. Astringents, tonics, and mild aperients must not be ignored, as also the influence of hygienic and local conditions, and subjects of the disease should be cautioned to provide against the admission of cold water into the ear in bathing.
Cigarette Smoking.—In cigarette smoking the tobacco leaf is reduced to very fine shreds, and it is consumed with great celerity. The smoke passes directly into the mouth, and whatever nicotine there may be to affect the organism of the smoker is taken up with especial avidity. The influence of cigarette smoking on the pulse is often strongly marked. The sphygmograph gives tracings which are characteristic of the depression produced by tobacco on the vaso-motor centre and nerves, and these tracings are more characteristic in the case of the habitual smoker of cigarettes than in that of the smoker of cigars or a pipe. The writer concludes, “We neither share the fashionable belief that alcoholic drinks are injurious when taken in strict moderation, nor do we for a moment think that a moderate use of tobacco is to be deprecated, except in special cases; on the contrary, we are convinced that for the relief of many mind and nerve troubles, and for the reduction of needless and mischievous excitement in the brain and other nerve centres, tobacco smoking is often useful; but at the same time we are persuaded that a protest against the habitual smoking of cigarettes is needed.”

Severe Hæmorrhage after Tooth Extraction treated by Transfusion.—The Revue Odontologique contains a case of almost fatal hæmorrhage after tooth-extraction. The patient, a young soldier of twenty-two, with a marked history of hereditary and collateral hæmorrhagic diathesis, was admitted to the Hôtel Dieu, and had some molar roots removed, without telling the house-surgeon any facts as to his history, and the operation was followed by profuse hæmorrhage of a dark color without clots. Next morning plugging with lint and perchloride of iron was tried without permanent effect. On the third day actual cautery was tried at the bottom of the socket, followed by sponge pressure, the jaws being fixed by a bandage, and ergotine subcutaneously injected. On the fourth and fifth there was no hæmorrhage; injections continued. Next day (sixth) the bandages were removed, owing to sloughing and suppuration of the gums, and from the raw surfaces profuse bleeding recurred, and no local measures were effective to arrest it. On the eleventh day the patient was moribund, and it was decided to try transfusion of blood. After plugging the socket again, 100 grammes of blood were transfused into the cephalic vein, with immediate relief. In three hours the trouble began again, and continued till next morning, when after a second transfusion the patient began to revive, although an access of
syncope nearly proved fatal during the operation. However the hemorrhage was stopped, and in six weeks the patient was discharged cured.

R. A. S.

MEDICAL TIMES AND GAZETTE.

FEBRUARY AND MARCH.

Elephantiasis, &c., due to the Abortion of the Filaria Sanguinis Hominis.—Dr. Manson points out that the embryonic filaria (those generally found in the blood) are contained in a spheroidal case whilst in their ova condition, and that the diameter of such an ovum is from five to six times greater than that of the hatched embryo.

The parent filaria (female) nearly always occupies the lymphatics on the distal side of the glands. If it aborts, as it occasionally does, these ova will act as emboli and block the lymph current, and as a result lymph scrotum, elephantiasis, &c., will ensue. The ordinary embryos readily pass through the vessels. In two cases of lymph oedema he has found these ova in the distended lymphatics, and believes that this process furnishes a key to the explanation of the whole pathology of the filarial diseases.

Maclagan on Rheumatic Endocarditis.—He desires to correct a statement which has been made, to the effect that the heart does not recover from rheumatic endocarditis, whilst the joints recover from their rheumatic affection. The endocardium proper is not primarily affected in rheumatism. It is injured by the swelling of the subjacent fibrous textures, which cause abrasion of the endocardial valvular surfaces thus forced into contact with one another. When under anti-rheumatic treatment the affection of the fibrous tissue subsides, the injury already done to the endocardium is often past repairing, and permanent valvular disease remains.

Removal of Tumours from the Anterior Mediastinum.—Dr. Kuster removed a tumour which was attached to the third and fourth right costal cartilages, and to the right side of the sternum. In doing so he removed those cartilages and part of the sternum, exposed the pericardium, cut the internal mammary artery, and opened the right pleura. The patient made an excellent recovery. Antiseptic precautions were used throughout the operation. The tumour proved to be a softening gumma.
Dr. König removed an osteo-chondroma of the sternum, and in doing so opened the pericardium and both pleural cavities. His patient, however, recovered.

Koch's Observations on the Tubercular Bacillus confirmed.—Mr. Cheyne has presented a report on the subject of the Relation of Micro-organisms to Tuberculosis to the Association for the Advancement of Medicine by Research. His conclusions may be summed up as follows:

(a) It is very difficult indeed to produce tuberculosis in animals (rodents) by putting setons into their tissues, by injecting vaccine lymph or pyæmic pus subcutaneously or otherwise, or by other such methods.

(b) Professor Toussaint's micrococci will not produce tuberculosis.

(c) That in every case where an animal was inoculated with Koch's bacilli, the animal became tuberculous, and the tubercles contained the bacilli in numbers which apparently bore no definite relation to the severity of the disease.

(d) The bacilli occupy epithelioid cells, which are for the most part derived from the epithelial cells of the pulmonary alveoli, and which may unite to form giant cells.

(e) Their rapid development is associated with caseous phthisis, and their slower development with fibroid phthisis.

Subcutaneous nodules in Rheumatism.—Dr. Money exhibited to the Clinical Society of London many specimens of fibroid subcutaneous nodules which occurred in the subjects of rheumatism. They were loose vascular fibroids, which were situated over joints for the most part, and which sometimes disappeared under treatment.

Solid Ovarian Tumors.—Mr. Knowsley Thornton has performed 338 ovariotomies, and has found solid ovarian tumours (mostly sarcomata) ten times. They differ from cystic ovarian tumours clinically, in being attended with irregular menstruation, and from solid uterine fibroid in causing emaciation and impairment of the general health. The immediate and ultimate danger of operation in such cases is much greater than in ordinary ovariotomies.

Suppurative Pericarditis treated by Free Incision.—Dr. West has recorded a case, which he treated in this way and which recovered. All previous cases so treated died, the heart being sometimes wounded during the operation of opening the pericardium.
**Nævus of the Rectum.**—Mr. Barker reports such a case, where the walls of the rectum were in a naevoid condition. On the mucous membrane were three small ulcers detected by examining the rectum with a vaginal speculum and a strong light. Haemorrhage took place at intervals, and finally proved fatal, treatment being ineffectual.

**Micrococcus of Erysipelas.**—Fehleisen has obtained and cultivated micrococci obtained from the lymphatics of a tissue affected by erysipelas. The results of his cultivation always produced erysipelas when inoculated. A 3 per cent. solution of carbolic acid destroyed their vitality in 45 seconds.

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**NEW YORK MEDICAL RECORD.**

**Transplantation of Portions of the Conjunctiva from the Rabbit to the Human Eye.**

Dr. H. D. Noyes has performed this operation many times since 1872, chiefly for symblepharon caused by burns, and also to increase the size of the conjunctival sac, that a patient might be enabled to wear an artificial eye. First, all adhesions must be separated, so that the eyeball and lids have their proper freedom. The rabbit is secured in a pasteboard box, out of which his head protrudes, and etherized. The whole conjunctiva is then dissected off with pointed scissors, curved on the flat, beginning at the inner canthus, and from the circumference towards the cornea. As the membrane is lifted, two threads of fine black silk, with needles attached, are put into one end of the piece, by which, when fully separated, it can be carried. It is then put in a saucer of tepid water, and fastened on to a submerged piece of cork by the points of the threaded needles. Then it is trimmed to proper shape, and carried on the cork to the eye, and two of the threads run from the piece into their places in the patient's eye. Then taking out the needles from the cork, their threads are drawn through the piece, which is pulled into its place and laid out smoothly. He applies the piece to both the ocular and palpebral surfaces, and to make the cul de sac the stitches are drawn through the lid and tied over a bit of stick on its outer surface. Dr. Noyes has in no instance met with entire failure, while the degrees of benefit have been various.

**Condensing Ostitis of the Mastoid Process.**

Under this title Dr. A. H. Buck describes a condition otherwise known as hyperostosis or sclerosis of the mastoid process, and
which is sometimes mistaken for suppuration or caries. It is apt
to be complicated, and is difficult of recognition clinically, but
may be distinguished by—

1. The persistence of pain, despite an adequate outlet for pus
   in the middle ear, or in the absence of acute inflammation
   in the middle ear.

2. External signs of redness, swelling, and tenderness, and
   especially actual enlargement of the mastoid.

3. History of previous chronic purulent inflammation of the
   middle ear.

The treatment is simple, consisting of subcutaneous drilling of
the bone.

Cysto-Abdominalraphy.

Dr. Alex. W. Stein records eight experiments on dogs, to test
the practicability of this operation, and thinks the results show
it to be a feasible one. In all the cases the bladder wound was
brought into apposition, and in union with the abdominal wound,
and firm adhesions formed between the bladder and abdominal
wall. All the cases did well, healing occurring by first intention
in three.

Treatment of Inveterate Pannus by Liquorice Bean or Jeguirity.

Dr. Emil Gruener reports two successful cases. The infusion
of the bean was applied to the inner surface of the lids three times
a day, and compresses moistened with the infusion kept over the
eyes day and night for five days. Brisk inflammation resulted,
and on the tenth day the patients were discharged with the
surfaces of the lids smooth and shining, while the vascular
injection and infiltration of the cornea had completely disappeared.

Equine Scarlatinal Virus as a Prophylactic against Human
Scarlatina.

Dr. J. W. Stickler records twelve cases in which he "vaccinated"
children with virus obtained from the nasal mucus of a horse
affected with equine scarlatina. In 24 hours a punctate redness
appeared at the site of the puncture. By the third day this red
eruption covered a space as large as the palm of the hand, and on
drawing a blunt scissors across it a white line was left, lasting
about a minute. The redness disappeared on the sixth day, and
was followed by desquamation. Subsequently human scarlatinal
blood was subcutaneously injected without effect, locally or
constitutionally.
JULY 15, 1883  
Australian Medical Journal.  

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Treatment of Ovaritis.  

Dr. Horatio R. Bigelow knows none of the diseases peculiar to women so unsatisfactory in its treatment, or so hopeless to the patient as is ovaritis. Specialists are apt to relegate the seat of the disease to the uterus, with the result "that misplaced uteri are supported with pessaries, lacerations are sewn up, vegetations removed with the curette, cervices depleted, and tonics given, but the patient finds no surcease from her suffering." Dr. Bigelow does not believe the cause of the distressing symptoms is ever found in the uterus, however misplaced it may be, or in however great a degree its mucous membrane has degenerated; nor can good results possibly obtain, if the secondary conditions are allowed to obscure the primary." Pessaries are only exceptionally beneficial. After trying many methods of treatment without avail, he finds that rectal suppositories of iodoform gr. $\frac{1}{4}$ combined with a small quantity of alcoholic extract of belladonna have given better results than anything else, combined with rigid attention to proper hygienic and dietetic rules, such as absolute rest, abstinence from sexual excitement, full diet, with electricity and massage.  

Phosphatic Incrustation of Urethra after Lithotomy.  

Dr. S. S. Kahn reports a case in which twenty days after operation the patient was seized with retention of urine, and all along the urethra hard nodules could be felt, preventing the passage of a catheter. An instrument was then passed through a fistulous opening in the perineum, and the bladder washed out with a one per cent. solution of boro-citrate of magnesia, which was also given internally in tea-spoonful doses every hour. Eight hours afterwards the child passed a quantity of softened calculous matter through the urethra; the nodules disappeared, and the flow of urine was comparatively easy, although still attended with pain. During the next night he passed some more calculous material. The treatment was continued for some time, but the patient has now had no recurrence for eight months.  

Professor Mundé considers there are many cases of non-puerperal uterine hæmorrhage, slight in amount yet very distressing to the patient, the causes of which are apt to be overlooked, unless a thorough vaginal examination is made, including the use of the speculum. These causes may be: 1. A trifling non-puerperal erosion of the cervix. 2. A laceration of the cervix, unhealed or
temporarily healed. 3. Chronic sub-involution. 4. Retention of blood from a flexion or a pin-hole external os. In laceration of the cervix he believes a permanent cure is to be obtained only by trachelorrhaphy.

Dr. D. B. St. John Roosa calls attention to the possible dangers from the injudicious use of quinine. Experiments made by himself and Dr. W. A. Hammond showed that sulphate of quinine in 10 to 15 grain doses caused vascular injection of the auricle, auditory canal, drum-head, conjunctiva, and possibly the optic papilla. Subsequent clinical investigations have shown that inflammations of the retina, or of the middle or internal ear not uncommonly follow the administration of large doses of quinine. The practice of taking large doses of quinine to check common colds is becoming very common, even with the laity, but Dr. Roosa thinks it is very reprehensible, being liable to cause extension of the disease to the ear. He strongly objects to the use of quinine in pyemia, as its action is to lock up the emunctories. "In malarial affections we are justified in taking the risk of injury to the organs of sight or hearing which may be involved."

Electricity seems a most successful method of treatment for extra-uterine pregnancy, as used by Dr. A. D. Rockwell, who has had seven cases, and in every one was successful in destroying the life of the fetus, which was either absorbed or subsequently expelled. There seems to be no doubt as to the accuracy of the diagnosis, as all the cases were seen in consultation with such men as T. G. Thomas, Emmet, and Marion Sims. No unpleasant effects were experienced, but he would give a word of caution in the performance of the operation, viz., the possible danger, in cases well advanced, of rupturing the sac by too powerful or injudicious applications. He prefers the galvanic current, using a strength varying from 16 to 24 volts.

Dr. E. S. Post has noted a pulse in the veins in certain conditions, the sphygmographic tracings of which are an exact counterpart of the arterial pulse, a slow ascent and a quick descent. It is most marked when there is an increased fulness in the veins, with arterial relaxation, such as occurs in valvular disease, with insufficiency, pericardial effusion, obstructions to the pulmonary circulation, &c. He says its recognition is not difficult in appropriate cases. "Having obtained the radial at the wrist, move the instrument half to one centimetre to the outer side of the arm, remit half the pressure, and if the venous pulse be present its tracing will appear."
Professor Leon Le Fort of the Hôtel Dieu, Paris, reports a successful case of *laparotomy* for acute intestinal obstruction of seven days duration, performed when patient seemed almost moribund, and without antiseptic precautions.

A case of *endocarditis* of the right side of the heart occurring in a foetus is reported by Dr. Josef Kucher. The three cusps of the tricuspid had coalesced and become sclerosed. All the other valves were healthy.

The occurrence of *tubercles* in which the Bacillus of Koch is not demonstrable.—Dr. J. Mitchell Prudden records several cases presenting the usual anatomical criteria of tubercle, in which on microscopic examination he could not find a single bacillus, although in one case he made as many as 909 sections, and used Ziehl’s method of staining to corroborate Ehrlich’s. The cases were such as from their history and macroscopic examination would be expected to furnish perfect examples of Koch’s theory according to the popular conception. Dr. Prudden, however, thinks the popular conception not quite correct. “For Koch the criterion of a genuine tubercle lies in its infectious nature, not in its anatomical character,” and, as far as he is aware, “Koch nowhere states, nor does the establishment of his hypothesis demand, that the bacilli should be bodily present in every tubercle.

*Aluminium in Phthisis.*—Dr. Julius Pick states that aluminium is a most active destroyer of the tubercle bacillus, and can therefore be rationally given as a remedy in the early stages of phthisis. He combines it with carbonate of lime to aid in the cretification of the tubercle!

*Arsenite of Bromine in Diabetes.*—Dr. R. H. Gilliford states that he has succeeded in producing a new salt, arsenite of bromine, by the union of bromine and arsenious acid. This has been prescribed with some success in diabetes, four cases being reported, all of which were improved, and one is said to be cured.

*Radical Cure of Hernia.*—Dr. R. A. Vance brings together the two lips of the hernial opening by means of deep-seated sutures passed sub-cutaneously with a semi-circular needle.

*Spina Bifida.*—Dr. R. T. Hayes reports a case successfully treated according to the method recommended by Robson of Leeds, viz., the application of fresh periosteal grafts from a rabbit to the surface of the membranes, after the superfluous portion of these has been removed.
Treatment of Synovial Disease.—Dr. H. A. Martin advocates the withdrawal of the synovial fluid by aspiration, and the application of the rubber bandage.

Curability of Chronic Uterine Catarrh.—Dr. Paul F. Mundé does not coincide in the general opinion that this disease is practically incurable, but has found that many cases, intractable to mild applications, will in a certain proportion get well under heroic, active, and persistent treatment. He advises—First, the enlargement of the external os by a crucial incision, and the removal of the four flaps of mucous membrane thus formed; next he thoroughly destroys all the cervical glands with a sharp curette and the application of fuming nitric acid. If the os be lacerated he performs Emmett's operation. He also uses constitutional measures, and treats the concomitant vaginal leucorrhœa with hot injections and painting with equal parts of the fluid extract of Hydrastis Canadensis and glycerine.

Operating to determine Sex.—A pseudo-hermaphrodite, age 22, had been brought up as a female. The face and chest were masculine; the breasts enlarged; the pelvis and lower limbs were like a woman's; the mons veneris was slightly developed. There was a vulva, well-developed clitoris, labia, short vagina, no penis, no prostate, no uterus. Near the inguinal region two round bodies could be felt, giving pain on pressure. The question was, were they ovaries or testicles? Prof. Porro cut down and found that the body was a testicle, with epididymis and cord attached. The patient was accordingly pronounced a man.

The sudden heart failure which sometimes occurs in acute infectious diseases, and especially in typhoid fever, may be due, thinks Dr. Beverley Robinson, "to a sudden and considerable dilatation of the cardiac cavities, especially of the right side." "Under these circumstances coagula may form, with fatal results; or, if the heart be immediately and strongly stimulated, the imminent stage may be tided over, and only incomplete failure occurs." The therapeutic indications are simple, viz.: Avoidance of all unnecessary fatigue during the whole duration of even mild cases. Patients should not be allowed to make the slightest exertion that can be avoided by judicious nursing. Cardiac tonics should be employed in moderate doses from a relatively early stage of the disease. Black coffee is a very valuable agent in this respect, and should be given with liquid nutriment in very concentrated forms.

G. A. S.
Cerebral Dyspepsia, by John S. Main, M.D.—The author strongly insists on the purely cerebral origin of many forms of dyspepsia, where the patient is neither over-indulgent, nor intemperate, nor addicted to hurrying over meals, nor accustomed to eat coarse or unwholesome food. The cerebral form of dyspepsia is well seen, in many cases, where a healthy man, with a good appetite, suddenly receives bad news when sitting down to a meal. 

"But, perhaps, of all conditions acting on the brain in this manner, and through the brain on the stomach, no one is more injurious, or more jarring to the cerebral elements, than uncertainty, and the worry caused by the same, more particularly in preternaturally irritable subjects. In fact, it is in connection with this same worry that the form of dyspepsia I have at present under consideration most frequently occurs. The mind in such cases preys upon itself; the cerebral elements seem to get jarred and out of gear: and with this condition the stomach sympathises. But, in addition to worry, the habitual practice of calling into action the 'reserve fund' of the cerebrum, as already mentioned, will bring about the same consequences—namely, cerebral fatigue and exhaustion, indicated chiefly by preternatural irritability, this condition sooner or later telling upon the digestive organs. Having said this, it is almost unnecessary to add that such cases are most commonly met with amongst those who are engaged in the hottest part of the 'battle of life,' or 'struggle for existence'; and, again, amongst these, chiefly those whose business or profession leads to much anxiety, uncertainty, or over-stretching of the mental powers. In over-aspiring, over-ambitious natures 'hope deferred' may bring about the same results; as, according to the biblical expression 'it maketh the heart sick.' My attention was drawn to several cases of dyspepsia connected with one or other of these conditions, some time ago; and what made me more strong in my view of these cases being cerebral, and not stomachic at all in their origin, was their obstinacy under all forms of natural treatment. Latterly I have found that the only treatment capable of doing these cases any permanent good, is a change, in the wide sense of the term—a relaxation from business or study; and as regards medicines, not such as are meant to act on the stomach directly, but those meant to act on the cerebrum. Amongst these, I have found the most useful to
be the bromide of ammonium, or bromide of potassium—preferably the former—given in a sufficient dose at bedtime to secure a good night's sleep, this being often very indifferent, and so tending to complicate the case; and combined with this, to be taken three or four times during the day, such medicines as are known to have a building up effect on the nervous system. Amongst these, the most useful are phosphorus, or the hypophosphites, and cod-liver oil. Arsenic and quinine are often also useful, and a generous diet is always indicated. Unless the stomach has passed into a state of disease (which it may do, if overtasked when in this weakened state), any of these medicines are generally well borne. It will be well to bear in mind, however, that if the mucous membrane of the stomach be in a state of irritation, quinine, arsenic, phosphorus, the hypophosphites, and sometimes even cod-liver oil, are generally inadmissible.”

BIRTH.

FLEETWOOD.—On the 14th inst., at Warrnambool, the wife of T. F. Fleetwood, F.R.C.S.I., of a daughter.

MARRIAGES.

CLARKE—GRANT.—On the 20th ult., at St. Saviour's, by the Rev. C. M. Yelland, by special licence, Geo. P. Clarke, second son of Jas. L. Clarke, F.R.C.S.E., surgeon Royal Navy, to Christina Grant, only daughter of John Grant, farmer, Griffith's Point.

RYAN—SUMNER.—On the 5th inst., at Christ Church, Brunswick, by the Rev. Dr. Bromby, assisted by the Rev. C. P. M. Bardin, Dr. Charles S. Ryan, second son of Charles Ryan, of Darriweil, Mount Macedon, to Alice Elfrida, second daughter of T. J. Sumner, of Stony-park, Brunswick.

RYAN—M'GIVERN.—On the 18th of April, at St. Ignatius' Church, Richmond, by Rev. J. Mulhall, M. J. Ryan, M.B. et Ch.B., to Maggie, third daughter of Michael M'Givern, Esq., of Abbotsford-street, Abbotsford.

VIRGOE—TELFORD.—On the 11th inst., at Thule, Elwood, by the Rev. J. Hay, Robert Benjamin Ayres, second son of W. R. Virgoe, Esq., of this city, to Jean Bisset, second daughter of the late James Campbell Telford, M.D., of Cobram, Deniliquin, N.S.W., also of Airdrie, Scotland.

DEATHS.

BARKER.—On the 2nd inst., at the residence of his father, 53 Latrobe-street east, Alexander Scot Barker, L.F.P.S., Glasgow, in the 36th year of his age.

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