A CASE OF DIFFUSED ANEURISM OF THE COMMON FEMORAL ARTERY—OPERATION—CURE.

By F. C. Batchelor, L.R.C.S., M.R.C.S., Dunedin.

M. C., married, three children, no miscarriages; a thin worn woman aged 28 years, but looking much older, consulted me first in November 20th, 1881, and gave the following history:—

For the last three years has been subject to bilious (l) attacks, and had an unusually severe one six weeks since, and while vomiting suddenly lost the power of the left leg for about half an hour. The following day she felt pains in groin, knee and ankle. This continued about a week when it gradually ceased. She resumed her work as usual for about a week more, when the left ankle began to ache, and the pain gradually extended up to the thigh. After a few days she noticed a swelling about the size of a walnut in the left groin, which throbbed as she lay her hand on it; the pain was gradually increasing, being as a rule worse at night. About three weeks ago, after an unusually restless night from the pain, she found in the morning the swelling in the groin very much increased, and it has been gradually increasing ever since, the pain being at times most severe. She has been rapidly getting weaker; has kept to her bed altogether; feels very ill, and is unable to eat.

On visiting her (Nov. 20th) it was evident that the woman was very seriously ill. She lay on her back with her thigh flexed and rotated outward, and dreaded the slightest movement on account of the severe pain it caused. On examination, I found a brawny, boggy, discoloured swelling (much resembling an abscess approaching the surface) filling up the whole of Scarpa's triangle, bulging upwards at Poupart's ligament, which it had somewhat pushed up. There was no pulsation to be detected, but pressure on the external iliac artery caused the tumour to become more flaccid for...
a few seconds. A soft thrilling bruit was to be heard over the whole tumour, which ceased on compressing the iliac artery. There was no pulsation in the posterior tibial; the whole leg was somewhat swollen. I kept the patient under observation for a day or two, and gave iodide of potassium, but the tumour was evidently on the increase, and she was rapidly becoming exhausted. So on November 23rd, assisted by Drs. Brown, De Zouche and Maunsell, I proceeded to operate. The pulse on that day was 160. Ether was administered, and an Esmarch bandage applied from the foot upwards, and secured above by a figure of eight elastic tube over the thigh and pelvis, a roll of bandage being used to make compression on the external iliac artery. Difficulty was experienced in using this bandage on account of the tumour being so high up that it quite displaced Poupart's ligament. I made a free incision of about four inches into the sac; black clotted blood was first extruded from the opening and was immediately followed by a gush of a bright arterial hue. Dr. Brown, who had charge of the abdominal aorta, instantly made firm pressure through the abdominal walls, and at the same time I passed my hand into the sac and cleared out all clots and fibrin. There was considerable difficulty in finding the opening in the artery, and the carbolic spray which we were using had to be stopped; the opening was at last, however, found, and was a small oval smooth-edged slit about \( \frac{1}{4} \) to \( \frac{1}{8} \) of an inch long, almost immediately below Poupart's ligament. A double silk ligature was placed under the artery after a good deal of trouble, as I feared wounding the veins, and the tissues surrounding the artery were all matted together. The vessel was tied immediately above and below the slit. Dr. Brown compressed the abdominal aorta throughout the operation. Whenever he relaxed his pressure in the slightest degree, as in changing his left for his right hand, there was immediately a gush of blood from the bottom of the wound, and this it was that finally directed us to the opening in the artery. The wound was dressed antiseptically, an elastic drainage tube being left at the bottom, but for nearly half-an-hour the spray had to be stopped altogether to enable us to search for the opening and tie the vessel. The leg was wrapped in cotton wool and bandaged.

For some days following the operation the patient seemed to progress favourably, the old aching down the thigh and leg entirely ceased, the temperature kept below 100° and the pulse fell
to 120. The day after the operation I noticed the dressings discoloured with discharge, but avoided changing them as the temperature kept near normal, and I did not wish to disturb her more than was positively necessary.

On the fifth day I detected some smell from the dressings, I therefore changed them and found the wound suppurating freely throughout, and subsequently dressed the case every alternate day.

On the eighth day she complained of a feeling of tension and stiffness all over the left leg, and great pain on attempting to move or flex it. I had her removed to a water bed; a day or two subsequently the right leg became painful, stiff and swollen, and it began to put on much the appearance of phlegmasia dolens. The pulse went up to 140, and the temperature ranged from 100° to 103°, but she took nourishment fairly well.

Bed sores began now to form, one large one on the sacrum and smaller ones on the trochanters. I began to entertain grave doubts as to her pulling through.

On December 30, or 37 days from the date of the operation, I was called to see her suddenly in the morning, as she was said to be bleeding to death. I found her collapsed, pulseless at the wrist, and apparently dying. I removed the dressings and found about 12 ounces of blood in the wound, the lower ligature having come away and lying in the clot; all bleeding had then stopped. I sent for Dr. De Zouche, and we discussed the advisability of tying the external iliac artery, but in her collapsed condition, with the suppurating wound so near and the probability of the haemorrhage proceeding from the distal end of the artery, we felt that any further operation would be almost necessarily fatal. I therefore remained by her some hours and had her watched constantly for three days. She gradually rallied from the collapse, and after a week seemed to have made up for lost ground. The wound slowly granulated, filled up, and healed. The stiffness has left the right leg, but the left still remains somewhat swollen, stiff and weak, but is slowly improving; the bed sores have all healed some months since, and she gets up daily in the chair and begins to get about the house.

The special points of interest seem to me to be:

1. The rupture of a large artery from violent retching.
2. The failure of Esmarch bandage to control the circulation, for although the bruit over the aneurism disappeared on the
application of the bandage, the gush of blood was most violent. I think, in fact, that the bandage rather increased the difficulty and danger in the case, for, the incision having to be made so high up, the bandage was very inconveniently in the way and the blood pressed into the general circulation must have increased the arterial tension.

3. The temperature remaining so nearly normal I was deceived into thinking the wound aseptic, and consequently delayed changing the dressings too long. Since this case I always change the dressings immediately discharge appears at the surface.

4. The spontaneous arrest of the secondary haemorrhage.

5. Her final recovery from a condition of most extreme weakness, accompanied by bed sores, phlebitis, and severe secondary haemorrhage.

REMOVAL OF A HAIRPIN FROM THE BLADDER.

By T. F. Fleetwood, F.R.C.S.I.

A. R., a single girl, æt. 23, was brought to me on 7th November. Her mother said there was a hairpin in her bladder for the past four weeks. She had been to another doctor, who failed to discover it. On passing a female catheter into the bladder, I felt it distinctly.

November 8th.—Dr. Owen having put her under the influence of chloroform, I passed a director into the urethra, then the index finger of my left hand between the director and the arch of the pubes. When its tip was through the sphincter, I removed the director, and gradually working my finger into the bladder, I felt the hairpin with its points nearest the urethra. A button-hook passed along my finger brought down the points easily, and it came away between the hook and my finger. It was already encrusted with phosphates. She suffered no incontinence of urine afterwards, and only a little soreness.

In the London Medical Record for April, 1876, Dr. Dittel mentions having removed the broken end of a meerschaum cigar-holder from the bladder of a woman æt. 40. In same journal for May, 1881, Dr. Mesterton reports the removal of a laminaria tent
from the bladder of a woman æt. 34. The tent was introduced into the urethra for painful micturition; the string broke on trying to remove it, when it passed into the bladder. It was removed by the aid of a Sims' uterine hook, guided by the finger.

Bryant, in his "Practice of Surgery," gives a case of the removal of a lady's stiletto from the bladder of a young woman, and says, "For the removal of such a thing as a hairpin a blunt hook may possibly be of use."

Warrnambool, 22nd November, 1882.

Medical Society of Victoria.

ORDINARY MONTHLY MEETING.

WEDNESDAY, DECEMBER 6TH, 1882.

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

Present: Dr. W. Barker, Dr. Valentine Browne, Dr. Le Fevre, Dr. Backhouse, Dr. A. G. Black, Dr. J. P. Ryan, Dr. James Robertson, Dr. Meyer, Dr. Walsh, Dr. Gray, Dr. Moloney, Dr. Phillips, Dr. Griffith, Dr. Burke.

Dr. James Robertson, the ex-President of the Society, occupied the chair.

Dr. Murphy and Dr. Brett were present as visitors.

Four gentlemen were nominated for election as ordinary members of the Society.

After considerable discussion, the remaining business on the notice paper was postponed, and it was agreed that a special meeting should be held for the nomination of the office-bearers of the Society, and for the consideration of the papers and exhibits about to be submitted.

SPECIAL MEETING FOR DECEMBER 1882.

Present: Dr. Hewlett, Dr. James, Dr. Girdlestone, Dr. Gray, Dr. Graham, Dr. James Robertson, Dr. Browning, Dr. Le Fevre,
Dr. Haig, Dr. Walsh, Dr. Williams, Dr. Bernays, Dr. Neild, Dr. J. P. Ryan, Dr. Couper Johnston, Dr. Meyer, Dr. Malcolmson, Dr. Allen, Dr. Rowan, Dr. Burke, Dr. Snowball, Dr. Stirling, Dr. Fyffe, Dr. M'Millan.

The President, Dr. Hewlett, occupied the chair.

Dr. Murch was present as a visitor.

Nomination of Office-bearers of the Society for 1883.

A ballot was held for the nomination of the office-bearers of the Society and the editors of the *Australian Medical Journal* for the year 1883. Dr. Neild and Dr. J. P. Ryan acted as scrutineers. The number of nominations was as follows:—For the office of President, 2; Vice-president, 8; Hon. Treasurer, 2; Hon. Secretary, 2; Hon. Librarian, 5; Committee, 23; Hon. Auditors, 6; Editors of the *Australian Medical Journal*, 9. Certain names, however, were at once withdrawn, having been used without authority.

Date of Annual Meeting.

Dr. Neild inquired when the Annual Meeting would be held.

The Hon. Secretary replied that for some years it had been customary for the Annual Meeting to take place on the second Wednesday in January instead of the first, as a fuller attendance was thereby secured.

The Hon. Treasurer remarked that the postponement of the Annual Meeting greatly facilitated the auditing of the accounts of the Society.

Beri-beri.

The Hon. Secretary notified that the paper on Beri-beri which Dr. Suzuki and Dr. Toyozumi, of the Japanese warship *Tsukuba*, had promised to contribute, had been duly forwarded through Dr. Willmott. It was of considerable length and of great interest, and was accompanied by a review on the same subject sent by Baron von Mueller. He would propose that the paper be received and entered among the Transactions of the Society.

The motion was seconded by Dr. James, and carried unanimously.
The paper is as follows:

KAK'KE, OR BERI-BERI IN JAPAN.

By Dr. SUZUKI AND Dr. TOYOZUMI.

Surgeons to H.I.J.M.S. Tsukuba.

The term "kak'ke" is derived from two Japanese words, "kiaku" and "ki," meaning leg and state respectively, indicating the prominent condition of the disease.

Definition.—A recurrent, non-contagious disease, attacking up to present time only the natives of Japan, selecting the residents of most densely populated towns, and particularly of the low crowded districts in these places; most prevalent during the period of high temperature and heavy rainfall; with or without rise of temperature; marked and temporary numbness of certain portions of the surface; paralytic affections, most commonly of the lower and upper extremities, but occasionally other parts, tending to atrophy, with spasm and tenderness, in the paralysed muscles; oedema, usually confined to the lower extremities, and palpitation.

Forms of Disease.—It may be divided into acute, subacute, and chronic forms; but there is no distinct demarcation between the the three, and one form may pass to another.

Incubation Period.—Very long, and if the poison once enters the system, the disease breaks out even when the patient is far separated from the district; after one attack, it readily awakes when the favourable time comes on.

Symptoms.

1. Disorders of Sensation.—Cutaneous anæsthesia most commonly appears in the early stage of the disease, and is one of the constant signs; the affected parts are the upper and lower extremities, especially the tips of fingers, legs, abdomen, and lips.

Muscular Tenderness.—In chronic cases the tenderness is most marked in the calves; sometimes the thighs and upper limbs are affected. Seldom seen in acute and subacute cases. Spinal tenderness and pain in and around the joints are sometimes seen.

2. Motor Disorder.—Paralysis develops slowly, and is localised to certain groups of muscles; generally first appears in lower extremities; then looseness of knee joint and inability to support the bodily weight follows; but paralysis is never complete unless in extreme chronic cases.
Spasms or Cramps, especially in calves.
Muscular Atrophy, usually in lower limbs.
Thickening and induration in the muscular fibres, especially in the gastrocnemius.

3. Circulatory Disorder.—Palpitation always present in acute and subacute cases; seldom in chronic cases, unless the case be transmitted from acute to chronic form.
Alteration of Heart Sounds: Murmurs.—Usually systolic murmur at base and apex; prolongation of first sound, duplication of second sound. These alterations are only temporary, and bear no special relation to anæmia. In acute cases, intensely embarrassed cardiac action, with tendency to contraction of smaller arteries; orthopneæa and cyanosis; perceptible and diffused fremitus in some of acute cases; pericardial effusion in moment of death in “Shiyoshin.”

4. Respiratory Disturbance.—Dyspneæa or orthopneæa present only during circulatory disturbance. In some acute cases there may be edema of lungs, or effusion into the pleura may appear, and then the patients are in most dangerous time.

5. Disorder of Digestive Organs.—Loss of appetite, thirst, constipation, nausea, and vomiting are common. Generally in kak’ke there is great tendency to disorder of digestive organs, even in slight cases. Liver normal; spleen rarely enlarged; when enlarged, the case is always attended with pyrexia.

Vomiting of Kak’ke.—Probably merely a symptom of grave general disorder, being accompanied and followed by rapid exhaustion, disproportionate to severity and frequency of vomiting. It may be checked by antemetics, but without greatly changing the course of the disease.

6. Dropsical Effusions.—Edema of legs most common, usually not involving the feet. The face is next in frequency; the chest, or even the whole body, being affected in a few of the acute cases. Effusions into serous cavities and into lungs seldom occur, and then are very dangerous.

Renal functions not specially affected; no albuminuria. In acute cases the quantity is much lessened.

Anæmia is marked in about 10 per cent. of cases.

Fever.—In some acute and subacute cases, during early stage, there is rise of temperature, ranging from 100° to 104° F. As the case goes on, generally the temperature comes down to the normal.
Mode of Death.—(1) Exhaustion, rapid or gradual; (2) Asphyxia and asthenia, from effusion into pericardium; (3) Asphyxia, from oedema of lung or from effusion into pleura.

Frequency of Attack.—In Army and Navy about 6 per cent. of total forces.

Mortality.—In Naval department 5 to 10 per cent.; in Army department a little more than this.

Morbid Anatomy and Pathology ought to be described here, but we have few post-mortem examinations, and the pathology is still in doubt, so we shall leave it till afterwards.

Etiology.

Locality.—Low overcrowded towns, with bad drainage and surrounded by marsh land.

Season.—Usually from May to October, during S.W. monsoon, but may appear in the other months.

Hygiene.—Bad drainage and overcrowding, especially if combined with bad ventilation.

Age.—Rare in childhood and old age; most common in period of greatest bodily vigour—20 to 30.

Sex.—More common in men than in women, probably because men, as marines, soldiers, &c., are more liable to overcrowding.

Rank and Occupation.—Least in higher classes, who live in healthy situations and large houses, and also in coolies, who live during the day in the open air. Most common in sailors and marines, who live in barracks, and people of sedentary habits, as students, merchants, shop-keepers, &c., who are confined during a great part of the day to their houses.

Race.—Disease confined at present to Japanese, as the foreigners are few, and are not subjected to overcrowding or other specially unhealthy circumstances.

Food.—Rice eating and drinking water seem to have no connexion with kak’ke.

Treatment.

1. Removal of, as far as we are able, the immediate and remote causes. Patient to be moved from unhealthy houses, low situations, and circumstances of overcrowding.

2. Neutralisation or elimination of kak’ke poison, if possible. Quinine has been tried often, but is useless as a specific; but it may be given as a temperator or tonic. Arsenic used sometimes,
but without much success. Sulphites useless. Eucalyptus, worth trial in cases with fever.

3. **Relief of Special Symptoms—Motor Paralysis.**—Strychnia and iron where no hyperæsthesia or muscular spasm. Electricity, valuable where there is muscular weakness or atrophy, without hyperæsthesia.

**Cutaneous Anaesthesia.**—No special treatment required; it soon disappears as the case progresses.

**Muscular hyperæsthesia.**—Aconite tincture in m xv. doses found most useful. Belladonna, chloroform, ergot, bromide, iodide of potassium, morphia, &c., occasionally alleviative.

**Circulatory Disturbance—Palpitation.**—Morphia injection, digitalis, m xv.—xx.

**Cardiac Acceleration of Acute Kakeke.**—Aconite, by subcutaneous injection, probably the most hopeful remedy; requires trial. Chloroform, ammonia, &c., useless. Venesection tried in the most acute cases, but without much success. Digitalis, morphia, useless.

**Digestive Disorders.**—Gastric irritation of the ordinary type:—Bismuth, soda, creosote for vomiting. Reflex vomiting:—Hydrocyanic acid, creosote and ice have been tried, but without definite result.

**Dropsical Effusions.**—Ordinary local œdema requires no treatment; more widely-spread œdema may be met with diuretics and purgatives.

**Effusions into Serous Cavities.**—Diuretics, purgatives.

**Operation** should be resorted to only in extreme cases. Paracentesis pericardii is dangerous unless the effusion is very great. In cases in which it has been performed no good effect has followed the withdrawal of the fluid. Paracentesis abdominis and paracentesis thoracis are rarely necessary.

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**DR. A. WERNICH’S ESSAY ON BERI-BERI IN JAPAN.**

A Review translated by Baron Ferdinand von Mueller, K.C.M.G., M.D., Ph.D.

In Virchow’s “Archiv für Pathologische Anatomie und Physiologie,” Vol. LXXI., Part 3, appeared an essay by Dr. A. Wernich, entitled, “Klinische Untersuchungen über die Japane-
sische Varietät der Beri-beri Krankheit." This important treatise became reviewed in the "Klinische Wochenschrift" of Berlin, 1878, p. 497; and it may be of some interest to add a translation of that review to the account given by Drs. Suzuki and Toyozumi, as specially written by them for the Medical Society of Victoria, the review above alluded to bringing the main results of Dr. Wernich's special observations under notice.

"The Japanese variety of the much discussed disease which, under the name of beri-beri, occurs on many of the islands and coasts of Asia, as well as of South America and Australia, became the object of discussion from Dr. Wernich's personal observations. His writing treats the symptomatology in an almost exhaustive manner, and deserves, as the first essay on the subject based on newer views and resources in medicine, particular attention.

The disease either runs a quick course under the features of severe disturbances of nutrition, accompanied by oedematous and frequently also paralytic affections, or it may pass on in a protracted manner. In Japan the disease shows itself during spring and summer, and seizes mostly on male natives, particularly young and middle-aged men, whereas females, children and aged persons are rarely attacked. There the malady is also known as kak'ke, and develops in various forms. The acute form commences suddenly with weakness of the legs and frequent vomiting; palpitations, objective and subjective dyspncea follow, caused by serous exudations into the pleural cavity and the pericardium; oedema arises in the face and in other parts of the body, and death takes place in two or three days, or even earlier. A second form of the disease runs on with less severe symptoms, and terminates gradually in recovery. Among the most frequent types of the beri-beri can be comprehended hydropic-marasmic affections.

While these were analyzed by the author, he obtained an insight into the whole variability of the disease, and got a clue to the alterations in the organs of circulation. The latter become in a high degree affected, so much so that their changes had already struck former observers, without a correct interpretation being arrived at. The blood-corpuscles are found to be smaller than in their normal state, and they lack the power of forming rows, indicative of a blood poor in serum, and insufficiently regenerated by new elements. The circulation in the veins
proved tardy, while the sphygmographic examination of the arteries offered important characteristics, which the author explained on numerous tables of curvatures. Thus it is shown that the pulse-curve very straightly ascends, forming with the first part of the descension-line an acute triangle, while the second part becomes strongly dicrotic; therefore within various modifications, the angle assumes forms which indicate laxness, want of resistance, and imperfect elasticity of the arterial tubes. Further observations did prove that the just mentioned abnormalities of the pulse-curve can be found to a small extent also in numerous anaemic individuals in Japan, that such can last through several years unaltered, that during the kak’ke season this curve in slight cases of illness becomes changed, but in severe cases assumes the above defined form. While re-convalescence goes on, the curve approaches very gradually to the normal one, just as gradually the blood ceases to be abnormal. As regards the heart no inflammatory processes were observed by the author; the peculiar systolic as well as the rarer diastolic sounds are to be regarded as caused by the anaemic state of the patient. All the other symptoms, such as the marked decrease of the urine, the strong development of hydrops anasarca, as well as ascites, hydrothorax and hydrops pericardii, with the appearances caused by them, further the giddiness, insomnia, cephalagia; furthermore, the characteristic decrease of sensibility, which proceeds from the lower extremities upwards, and which is accompanied by paraplegic affections of a peculiar progress, all these symptoms find their explanations, according to Dr. Wernich, readily in the decomposition of the blood, and in that want of energy of the vascular system which leads to hydropic effusions, and which manifests itself also in the cerebral and spinal organs and thus causes the nervous symptoms. A small number of post-mortem examinations, instituted by Dr. Wernich, as well as a critical investigation of published results of necroscopic obductions have demonstrated, that besides the hydropic affections and the serous exudations, which in the spinal cord may reach even to mollification, no essential or inflammatory changes take place in any organs, above all not in the kidneys nor heart.

In reference to the strange subjective feeling of illness at the outset of the disease and to the fever, which latter accompanies it frequently but not always, we are to remark that the height of temperature is very changeable. The mortality from beri-beri
amounted in India to 29 per cent., but in the beginning of epidemic acerbations to even 40 per cent. In the Japanese variety of the disease it came during the worst months to 15 per cent., but over the whole year to not fully 8 per cent. The nature of the malady is sought by the author in a decomposition of the blood, through which the serum loses its faculty to maintain itself in the organs of circulation, whereby partly the strong hydropic effusion and partly the abnormal quality of the remaining blood are caused. As far as the ætiology of the disease is concerned, Dr. Wernich thinks that the mode of living predisposes to it, notably the want of sufficient fatty and albuminous aliments, that the moist-warm climate of Japan impaires nutrition also, and that increased exertions, whether bodily or mental, augment the indisposition to a real disease. It is not necessary to assume as the cause of the beri-beri an infecting miasma. The author places this morbus, as he explained in another journal (Deutsches Archiv für Klinische Medicin, vol. xxi., part 1), with pernicious anaemia, chlorosis and scorbutus in so far together as all these arise from disturbed nutrition, which for long periods can be latent, but by increased tax on the system leads to cachexia, with frequent exitus lethalis.”—So far this able review of an important medical subject.

When Staff-surgeon Suzuki and Assistant-surgeon Toyozumi were reading over to me their rough notes on the Beri-beri, I at once remarked, that the origin of the disease seemed to me malarian. This view may be quite reconcilable to Dr. Wernich’s thoughts, inasmuch as ill-nourished individuals would be all the more susceptible to the inroads of those subtle organisms which, as we now know, are concomitant to miasmatic fevers. How bacteria have evaded the most vigilant searches of pathologists through long times has more recently been evinced by Dr. Koch’s discovery of the bacillus connected with tubercular phthisis. The sudden outbreak of the beri-beri in the hot season, and the occasionally great vehemence of its appearance, would speak for the presence of one of those infectious organisms, which only the most perfect microscopes and the most careful chemical manipulation can lay free to view. Indeed, cholera Asiatica, pestis nigra, synochus icterodes, hydrophobia, and some other dreadful diseases, the causes of which are yet more or less involved in obscurity, can in our present state of science be only assumed to send forth their deadliness through myriads of organic beings, as marvellous in
their minuteness as in the rapidity of their multiplication, but
doubtless destined to become subdued by the advancing strides of
rational medicine.

5th December, 1882.

The following paper was then read:—

NOTES ON A CASE OF CEREBRO-SPINAL FEVER.

By J. P. Ryan,

Chevalier of the Legion of Honour.

The subject of those notes was M. A. C., aged 17 years, a
seamstress, with dark hair, fair skin, and of nervous temperament.
When twelve years old she had a mild attack of chorea, and for
the last two years has had slight lateral curvature of spine; in
other respects she has enjoyed tolerably good health and was
fairly well nourished.

On Wednesday July 26th she was at her work as usual, and
went to bed well, but awoke at midnight with a strange feeling
of oppression and stiffness; she felt ill and frightened, and got up
to go into her mother’s room, but was quite giddy and found
herself scarcely able to stand. When her mother saw her she
was shivering, and complaining of violent frontal headache. Her
feet were bathed in mustard and water, some hot brandy and
water given to her; she was put to bed and warmly covered, and
soon fell asleep.

On Thursday morning she got up, but had to go to bed again
on account of headache and giddiness, and she passed an uneasy
night.

On Friday she felt somewhat better though still giddy, she had
some breakfast, and went to her employment. But whilst at work
she was again attacked with shivering, giddiness, and severe
headache, and was obliged to be assisted home. She was seen
by me in the afternoon, and complained of giddiness whilst
in the upright position, and of headache affecting the forehead
and vertex. Her face was pallid, skin not hot to the touch,
tongue white, bowels confined for two days, pulse 110, and temp.
101° in the mouth. I prescribed for her a purgative powder, a
hot mustard bath for feet and legs, cold applications to the head,
and perfect quietude. She vomited after taking the powder, and
on two or three occasions after drinking, and passed a restless night.

I did not see her on Saturday, but the headache and giddiness continued, she vomited occasionally, without nausea, and began to experience a feeling of stiffness all over her body.

Sunday, July 2, noon.—Pulse 106, temp. 103°. She passed a restless night, and vomited several times. Her face is somewhat flushed; tongue slightly coated; bowels open yesterday; abdomen retracted, not tender; and she still complains of frontal headache and giddiness. She lies on her back with her head low, knees drawn up, and is slightly deaf. To have calomel gr. vj. to be followed by a large enema of soap and water; head to be shaved and ice bag applied.

10 p.m.—Pulse 110, temp. 102.7°. The bowels opened freely twice. There was no vomiting, and she took a small quantity of broth as well as some lime-water and milk.

Monday, July 31, 9 a.m.—Pulse 96, temp. 100.1°. She slept for a couple of hours in the early part of the night, but was afterwards very uneasy, dozing a little, and then starting suddenly complaining of pains in her back and legs, and pain and stiffness in the back of the neck. The muscles of this part though not contracted are tender, and it hurts her to move her head. The headache and giddiness are less, but she complains of weakness of her right eye; is markedly deaf.

Tuesday, Aug. 1, 10 a.m.—Pulse 105, temp. 101.7°. Passed a restless night, sleeping a little and then crying out with pain; bowels opened by enema, the motion being semi-solid and dark coloured. She vomited twice and had besides some dry-retching. The tongue is brown and dry. She complains of the sight being dim, the lids are red, and covered with a gummy discharge; there is diffused pink coloration of the globes, the cornea looks dull, and both pupils are dilated.

Wednesday, August 2nd, 11 a.m.—Pulse 115, soft; temp. 101.5°. Another restless night, complains much of lightning pains in back, abdomen and thighs, and her whole surface is morbidly sensitive to the touch. To have a teaspoonful of brandy every two hours. At 7 p.m. her pulse was 112, temp. 101°.

Thursday, August 3, 9 a.m.—Pulse 120, soft and compressible, temp. 102°. She had scarcely any sleep, and was constantly crying out with pain. The headache is not so troublesome, and is felt principally at the vertex and back of the head. Tongue
moist and slightly coated, the skin dry but not hot. The pupils are widely dilated, the cornea hazy, and she cannot count the fingers held close to her face. She has had no vomiting since yesterday, her bowels opened once, the urine is scanty and high coloured, but free from albumen. Her mind is quite clear and her memory good, as she can recall all the stages of her illness. She feels that she is very ill, and says so, and is anxious to know if she will recover. I ordered her $\frac{1}{6}$ of a grain of muriate of morphia every four hours.

6 p.m.—Had a dose of her medicine at noon; she has been easy, and has been dozing nearly ever since, waking up occasionally to ask for a drink. Pupils dilated, pulse 115, temp. 101.\textdegree F. To have half a dose of medicine if she gets restless and again has pains.

Friday, August 4, 11 a.m.—Pulse 130, very soft and compressible, temp. 103\textdegree F. She was tolerably easy during the first part of the night, but about 4 a.m., as the pains were again troublesome, she was given half a dose of her medicine which had the effect of tranquillising her. She is beginning to cough, and gets up some whitish mucous expectoration. A few moist râles are audible at the bases of both lungs.

Saturday, 5th August, 10.30 p.m.—Pulse 144, temp. 101.7\textdegree F. She was very restless during the night, but did not suffer so much from pains, and did not require her medicine. A few bullae, varying in size from a split pea to a cherry, have come out on her lower arms, hands, legs, and feet, and her abdomen is tympanitic, but not tender on pressure. Her face is shrunken and drawn, and somewhat suffused; tongue dry, pulse very soft and compressible, and moist râles are audible all over back. She is becoming drowsy, but if aroused still answers questions intelligently.

Sunday, 6th August.—She was wandering in her mind during the early part of the night, became drowsy towards morning, and died quietly at 9.30 a.m. When I saw her at noon, the skin, particularly of her face, abdomen and legs, had already become very dark, and several bullae made their appearance on the fingers of both hands after death had taken place. No post mortem was obtainable.

As the disease under consideration has not, so far as I know, prevailed to any extent in the Australian colonies, or at all events has not hitherto been noted, there may be some doubt as to
whether the case I have just described is one of cerebro-spinal fever. But the sudden onset, shivering, persistent headache, vomiting without nausea, lightning pains in abdomen and legs, stiffness of muscles, inflammatory changes in ear and eye, vesicular eruption on skin, associated with a febrile temperature, and running an acute course, are so marked and peculiar as to be pathognomonic of the disease.

It may be urged that cerebro-spinal fever occurs as an epidemic, and it may be admitted that such is generally though not always the case. For instance, Dr. B. W. Richardson saw a single case at Mortlake, in Surrey, in 1843. From 1846 to 1850 sporadic cases occasionally made their appearance in Dublin, after which there was a complete cessation of the disease in Ireland until it again made its appearance as a severe epidemic in 1865. I myself saw one case there in that year, and in 1867, in the Chilian Republic of South America, two others, both of which were fatal, occurred in my own practice. Unfortunately I could not obtain permission to make a post mortem in either case, but the symptoms in both were well marked and unmistakeable. The treatment was almost altogether expectant, for I am not aware of any remedial measures, and many divers ones have been tried, that have in any way influenced the course of the disease.

She was kept in a clean, thoroughly ventilated apartment, supported, as far as the vomiting would allow, by bland nourishment, consisting mainly of milk and broth; her head was shaved, and the ice-cap pretty continuously applied to it; and later on she had a few small doses of morphia, which greatly alleviated the agonising pains from which she was suffering.

Dr. James Robertson stated that he had never seen a case of cerebro-spinal fever, and, until Dr. Ryan read his notes of the present case, he had never heard of the disease prevailing in this colony. It occurred chiefly on the Continent of Europe, especially in the cold climates; there had been two epidemics in Ireland, but it manifested itself chiefly in Norway, Sweden and Denmark; it was also frequently described in the United States of America. Usually it assumed an epidemic form, and the general belief was that it is a contagious disorder, this opinion being more and more confirmed by the experience of recent years. But the present case did not appear to be one of cerebro-spinal fever; it might rather be called meningitis, especially affecting the base of the brain and
spinal cord. Simple idiopathic meningitis might cause similar symptoms, such as fever, headache, giddiness and vomiting, though there was usually more mental disturbance than was noted in Dr. Ryan's patient. In cerebro-spinal fever there is usually delirium; here the mind remained clear; the period of death, the 14th day, might tally with cerebro-spinal fever, which may prove fatal in a few hours or may last for weeks. He observed, too, that the febrile movement was never very high except on two occasions when it reached 103°. In cerebro-spinal fever there was usually photophobia, with contracted pupils and increased susceptibility to noises; here there was rather dimness of vision, the pupils afterwards becoming dilated. Again in cerebro-spinal fever the eruption assumed the form of herpes about the mouth, and a purpuric eruption, not bullous, on the extremities and trunk; here there were distinct bullae, such as he had not seen described by any authority as occurring in cerebro-spinal fever. The characteristic symptoms of this disease were not well marked in the present case, as for example the retraction and spasm of muscles, the intense hyperaesthesia, intolerable headache, and delirium passing into stupor and coma. Hence he thought that caution should be exercised in giving a name to a disease of so doubtful a nature, more especially the name of cerebro-spinal fever, which is almost more alarming than small-pox. Before Dr. Ryan's diagnosis could be accepted we must be prepared to believe that a disease so characteristic could spring up without appreciable cause and pass away without being communicated to anyone else. More evidence of the real nature of the case was wanted; no post-mortem had been made; but, even if it had, the pathological appearances of cerebro-spinal fever are very much those of meningitis. In these colonies we find severe diarrhoea rapidly proving fatal, and then often termed English cholera; but such cases are never looked upon as true Asiatic cholera; and the same distinction should be made between severe meningitis and genuine cerebro-spinal fever; the latter is really more of the nature of cholera or typhus, prevailing in epidemics, yet not so contagious as the true exanthemata. He must repeat that the name Dr. Ryan had assigned was one liable to create alarm, and medical men should be cautious not to do so unnecessarily. The free use of the term "small pox" had been followed by a period of great excitement. In conclusion, he remarked that the young lady seemed to be very delicate; she had been subject to
chorea, and had spinal curvature; it was just possible that the
disease was really tubercular meningitis, which would account for
all the symptoms; but he did not feel inclined to believe the case
one of genuine cerebro-spinal fever.

Dr. James asked if there was any family history pointing to
tuberculosis?

Dr. J. P. Ryan replied in the negative.

Dr. Girdlestone thought the history was not very conclusive; it
was unfortunate that no post-mortem examination was held.
Cerebro-spinal fever and meningitis were closely related to each
other as regards their symptoms, and with the one isolated case
the diagnosis was not proved. But he had risen in especial to
reply to some remarks which had fallen from Dr. Robertson to
the effect that if the disease were called cerebro-spinal fever it
would give rise to some alarm. In the same way they had been
told that the recent cases of small-pox were not to be called small-
pox, because this again would give rise to alarm, because in fact
it would interfere with mercantile prosperity. As a scientific
Society, they should unite to discountenance such talk; they
wished to know the truth, careless whom it might disturb.
Dr. Robertson's speech appeared to be just a little tinctured with
the feeling to which he alluded, and hence he had arisen to protest
against it.

Dr. Robertson replied that he did not say for one moment
that a disease actually present should not receive its proper name.
But in doubtful cases we should be very careful not to cause
unnecessary alarm; and cerebro-spinal fever was most fatal, even
more so than small-pox.

Dr. Rowan inquired whether Dr. Ryan had any suspicion
about an extension of the old spinal disease into the spinal
canal? Many of the symptoms might be accounted for in that
way.

Dr. J. P. Ryan, in reply, reminded members that in his paper
he had referred to the isolated nature of the case as furnishing
ground for doubt whether it could be one of cerebro-spinal fever.
But other solitary cases had also been noted, as for example
Richardson's case already alluded to, and others which could easily
be cited. In his own experience he could only recollect one case
in Dublin. He saw two others in Chili about 1866-7. There
had been a severe epidemic in Ireland. In one of the two cases
he availed himself of the advice of Dr. Petit, one of the most
eminent physicians of the country, who had also personal experience of the disease in France. Dr. Petit declared it to be distinctly cerebro-spinal fever, and yet both cases were isolated ones, apart from any local epidemic. Great numbers of cases do occur sporadically without any spread of the disease; and as to the question of contagiousness, authorities are divided. Even if it is proved to be contagious, that is no reason why it should not sometimes appear in sporadic form. It was true that it occurred chiefly in cold climates; but there had been severe epidemics in Algeria and in the Southern States of America. It occurs in cold, temperate, and hot climates, being bound in this respect by no rigid law. The duration of the present case agreed with that of cerebro-spinal fever, which usually runs its course in from one to two weeks. He could not see how the disease could be classified otherwise; it had no resemblance to simple or to tubercular meningitis; he had taken accurate notes daily, and held that the peculiar contraction of the muscles at the back of the neck, the lightning pains in the body, the special range of temperature, and the presence of eruption, were characteristic of cerebro-spinal fever. As to the nature of the eruption in that disease, it was not always mere herpes; vesicles of all sizes do occur, and not uncommonly. The curvature of the spine was purely lateral, due to debility, and not to any special disease. As to giving alarm, he had allowed months to pass before publishing the case; at the time he communicated only with Dr. Williams, who unfortunately was too busy to visit it with him.
Hospital Reports.

MELBOURNE HOSPITAL.

Case of Strangulated Hernia.

Under the care of Dr. Beaney.

Reported by J. N. Mullen, M.B., Ch.B., House Surgeon.

E. M.D., a man æt. 59, was admitted on 14th November, 1882, at 9 a.m., suffering from vomiting, constipation, colicky and dragging pains about navel. The vomiting was of a bilious character; the abdomen was distended and tympanitic. Over the left inguinal canal there was a swelling, which was tense and very painful to the touch, and gave no impulse on coughing.

The patient states that he has been ruptured on the right side for the last 17 years, while on the left side he has had a rupture for the last three months. He has been able to reduce both ruptures easily, and he wore a double truss. About twelve hours prior to admission he was running about without a truss, when the hernia on the left came down, and he was unable to reduce it, though he endeavoured to do so during the greater part of the night.

3 p.m.—Patient put under chloroform, and incision made over the left inguinal canal. The sac of the hernia was opened, and some dark reddish fluid escaped. The intestine was somewhat congested, and was firmly adherent to its sac. The stricture was divided and the hernia reduced. The stricture was at the internal abdominal ring. Deep catgut sutures were introduced, and the wound dressed antiseptically. Morphia gr. ¼ given hypodermically.

5 p.m.—Patient sleeping.

5.30 p.m.—Feeling easy; no inclination to vomit.

8 p.m.—No vomiting; temp. 99.8°. Passed some flatus per anum.

Rx
Liq. Opii sed. ml. xx
Chloral hydrat. gr. xx.
Aquæ ½ j hac. noct. sumend.

15th November.—No vomiting since operation, nor any inclination to do so. Slept well; bowels not open; temp. 99°. Slight pain across loins; abdomen not tense; passed some flatus.
16th.—No vomiting; bowels not open. Slight pain across the abdomen and round the loins; slight tympany. Slept well after hypodermic injection; temp. 99°. Takes his milk and jelly well.

Rx
Hydrarg. subchlor. 5 j.
Sacc. alb. gr. x.
Fiat pulv. Statim sumend.

To be followed by:

Rx
Magnes. Sulph. gr. xc.
Magnes. carb. gr. x.
Aq. Menth. pip. 3 j. 3tiis horis.

17th.—Bowels open four times last night; no vomiting; slept well. Feels much better.

18th.—Slept well; bowels not open since yesterday; wound looking very well; no abdominal tenderness; temp. 99°. Dressed antiseptically.

19th. Redressed; feeling very well; bowels well opened yesterday. 5 p.m. Complains of colicky pain in abdomen; skin cool; abdomen relaxed.

Rx
Ext. belladonnae, gr. ¼.
Ext. gentian, q.s.
Fiat pil., cap. j. 6tiis horis.

20th.—Bowels not opened since 18th. No vomiting; tongue cleaning; abdomen relaxed; slight pain about the wound.

21st.—Bowels open yesterday.

22nd.—Feels very well.

23rd.—Wound closing; has difficulty in passing his urine.

26th.—Wound healed, there never having been any suppuration. Still complains of having difficulty in passing his urine. No. 1 catheter passed through a stricture in the membranous portion of the urethra. Catheter left in for about an hour, when a No. 10 silver catheter was passed through the stricture and left in for about two hours, when it had to be removed on account of its causing pain.

27th.—Patient somewhat feverish; temp. 101°. Tongue coated; has passed his urine freely.

Rx
Hst. Ammon. acet. 4tiis horis.
Rx

28th.—Much better; temp. 98°. Passes his urine freely; bowels not well open during last few days.

Rx
Ext. Colocynth. co.
Hydrarg. subchlor. aä gr. x.
Fiat pil. iiij. Capiat hac nocte.
29th.—Bowels well open after pills.
1st December.—Still pain in passing his urine.
3rd.—No. 8 gum elastic catheter passed easily through stricture.
4th.—Feels quite well; can pass his urine easily. Wound of operation has been healed some time. Discharged.

Case of Epithelioma of Tongue.
Under care of Mr. E. M. James.

Reported by J. N. Mullen, M.B., Ch.B., House Surgeon.


Patient states that about three years ago he noticed a crack on the right side of the tip of his tongue. He took no notice of it till about one month ago, when his tongue became fissured down the middle and increased in size without any pain. Patient used to smoke a great deal, the kind of pipe being either meerschaum or wooden. No history of syphilis. Father died aged 54. Mother and two sisters died of consumption. The tongue has a large fissure down the centre, with everted edges, the fissure extending some distance back; the parts around fissure are hard and unyielding.

9th October.—Lotio potass. permang., saepe utend.
26th October.—Patient operated on. The attachments of the tongue to the floor of the mouth were divided by means of the cautery scissors, and the tongue was cut through at the back by means of the wire eraser.
27th October.—Milk administered by means of a tube passed through the nose, but as it caused a good deal of distress, enemata were resorted to. Patient unable to swallow.
28th October.—Passed restless night, but complains of no pain. To have morphia hypodermically.
30th October.—Sleeps well at night after morphia. Can now take food by the mouth fairly well. Still foetid odour of breath, mouth being washed out with Condy's fluid.
2nd November.—Hst. quinie, ter in die sumend.
12th November.—Progressing favourably.
20th November.—Floor of mouth healing rapidly.
30th November.—The mouth has now almost healed. The sub-maxillary gland on the right side has a suspicious tendency to
hardening. The patient is in very good health, and there is no difficulty in understanding him when he speaks; has no pain; sleeps and eats well. Discharged.

A Case of Longitudinal and Transverse Fracture of the Tibia, accompanied with extensive Extravasation of Blood into the Tissues of the Leg.

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

Reported by T. Loughrey, M.B. Ch.B., House Surgeon.

William Wright, ae. 20, was admitted into the Melbourne Hospital on the evening of May 25th 1882, suffering from a severe injury to the leg, which was caused by a cart he was driving overturning and then falling on to his leg. On examination the limb was found to be very much swollen and discoloured, due to the extravasation of blood. No fracture could be detected owing to the swelling, and the patient was able to raise his leg from the bed straight up, and to move it about in all directions, but he could not stand upon his foot. To relieve tension a longitudinal incision was made, extending from a little below the head of the tibia to nearly its lower third, when, on removing the clots a longitudinal piece of the inner surface of the tibia, about four inches in length and an inch in width, was removed from the bone, from which there was oozing from the cancellous structure. In order to remove the whole of the clots of blood the incision was extended downwards about another inch, when a transverse fracture of the tibia was also discovered.

So extensive was the extravasation of blood and the contusion of the soft parts that amputation was seriously contemplated; but as the patient was a strong healthy country lad it was deemed advisable to give him a chance.

Into the wound a drainage tube was placed, and the limb placed on a M’Intyre’s splint kept at a slight incline. Two lateral splints were also applied, the inner one being interrupted over the wound, the outer one being a Cline’s splint.

The limb was then swung and made comfortable.

The whole operation was conducted with strict antiseptic precautions.

May 26th.—Slept fairly well last night after the hypodermic

May 27th.—Slept well last night. Complains of slight pain in the wound. Temp. 99°. Wound re-dressed antiseptically; surface covered with streaky pus; the bone at the seat of the longitudinal fracture is somewhat blackened. Discharge is quite sweet. The skin over the outer side of leg is tense and swollen. Incision made and drainage tube inserted.

May 29th.—Again dressed. Pus is blood stained; limb comfortable; discharge sweet. Health keeping up fairly well; bowels not open. Limb is to be dressed daily.

June 3rd.—Granulations are springing up over the surface of the wound, which is bathed with laudable pus.

June 26th.—Skin grafts applied to the wounded surface. Drainage tubes now removed.

July 4th.—Most of the grafts have taken, and now the wound is beginning to contract. Is complaining of pain in the calf of the leg. Back splint removed to-day for the first time since the operation. Fair amount of union has taken place in the fracture. Splint re-applied.

July 12th.—More skin grafts applied.

July 15th.—Grafts have all taken.

August 14th.—Union firm; surface of wound quite healthy-looking; plaster of Paris splint applied to the limb, leaving a trap door about three inches in length in order to admit of the wound being regularly dressed with ol. carbol.

August 16th.—Allowed to move about on crutches.

September 1st.—General health is greatly improved. Still a breach of surface over original wound, the edges being separated for about half an inch, owing to their being bound down to the periosteum.

September 9th.—Discharged from hospital, some “lotio rubra” being allowed him for dressing. Received instructions to return if not improving.

September 29th.—Returned to hospital to-day. Wound not very healthy-looking, granulations being exuberant; discharge thin and unhealthy; plaster splint removed; poultices applied;
states that a small piece of bone came out over the seat of longitudinal fracture.

November 30th.—Is still in hospital; wound gradually but slowly becoming smaller. The edges of the wound are to be elevated. Has now a very useful limb.

**Dislocation of Knee Backwards, and Comminuted Fracture of Patella, becoming Compound.**

Under the care of Mr. Fitzgerald.

Reported by G. Adlinton Syme, M.B., Ch.B.

Resident Medical Officer.

W. J. F. was admitted under the care of Mr. Fitzgerald on 16th June, 1882. He had been knocked down by a heavy case falling on his back, and as he fell his right leg twisted under him. His right knee was extensively bruised and greatly deformed. In front the skin was tightly stretched over the condyles of the femur, from off which the head of the tibia was displaced backwards. The patella was greatly comminuted, the largest fragment being drawn up the thigh by the quadriceps extensor. The whole joint was much swollen.

The dislocation was easily reduced under chloroform, and the leg was placed on a back splint, with a pad under the head of the tibia, and the leg swung and trunk raised to relax the extensors of the thigh. Ice applied to the joint.

Next morning there was considerable synovitis; but by the 20th this effusion had diminished sufficiently to allow of the fragments of the patella being brought together, and fixed by adhesive plaster and elastic extension to overcome the action of the quadriceps muscle.

On the 27th the bruised tissues in front of the joint began to slough, and on the 1st July effusion again occurred in the joint; and on the 3rd the joint was opened up by the sloughing, and synovia and serum escaped. A drain tube was inserted, and joint dressed by Lister's method.

Suppuration then set in, and the joint discharged freely. On the night of the 6th his temperature rose, and he became a little delirious; and on the 7th two free incisions were made into the joint, one on each side, and extension applied to the knee. The fragments were now a good deal separated. The swelling of the
joint gradually diminished, and there was very little pain. Temperature became normal, and his general health kept good; still the joint continued to discharge a little pus. At the beginning of August some oedema occurred on the inner side of the thigh, and pus was found to be burrowing up the thigh. A free incision, about three inches long, was made under the carbolic spray. By the 30th all the wounds were closed. There was no effusion in the joint, and no pain, and the joint felt firm, with some union of the patella, though the uppermost fragment was separated about three-quarters of an inch from the lower. The limb was then put up in a dextrine and cardboard splint. This was taken down on the 10th of September, when there was very firm union of the patella. No pain, hardly any deformity, and some mobility of the joint. The splint was taken off, and he was discharged on the 18th of September with a good, useful limb.

A Case of Tuberculosis.
Under the care of Dr. Williams.
Reported by J. W. Barrett, M.B., Ch.B., Resident Medical Officer.

Michael B., aet. 30, single, admitted 1st August, 1882. Three years ago patient first noticed a small swelling in front of the left ear. This increased, softened and burst, and then healed and burst again. This went on several times; then the swellings increased, extending down toward the clavicle; shortly after the right side became affected also. The swelling was not very painful, but it interfered with the movements of the mouth.

He had a short dry cough for three weeks before admission. His appetite has been bad, and his bowels constipated.

Previously he had been fairly healthy and had no ascertainable family history of disease.

When admitted there was great enlargement of the glands of the neck on both sides, over the clavicles and in the axilla. A few were well-marked and distinct, but for the most part they were blended together. Several were softening and breaking down. There was marked flattening beneath the clavicles, dulness on percussion at the right apex. The breath sounds were harsh here. At the left apex the breathing was indistinct. The vocal resonance was greatly increased at the right apex. The patient was
exceedingly emaciated. Had no appetite, and was very pale and weak. Had a frequent cough, and subsequently copious purulent expectoration. The temperature was very variable during the whole time he remained in the hospital, falling in the morning often to normal, and rising at night to 100°–103° F.

He rapidly sank and died, August 29th, 1882.

At the autopsy, a chain of scrofulous glands was found extending from the lower jaw downwards on both sides of neck, along both anterior and posterior mediastina into the abdomen. On the left side of the neck the glands were larger than on the right, and one large group near the angle of the jaw had undergone softening. In the anterior mediastinum several glands were thoroughly cheesy, and were closely adherent to the sternum. The glands along the borders of the pancreas were similarly affected, and of very large size, becoming united into coherent masses, which were also adherent to the suprarenal capsules and to the semi-lunar ganglia, especially on the left side. There was no bronzing of the skin. The mucous membrane lining the upper part of the larynx was much swollen; small oval ulcers were scattered through the trachea; there was thin turbid effusion into both pleural cavities, the surfaces of the lungs being studded with yellowish tubercles and large patches of false membrane. Both lungs were densely infiltrated with tubercles; there were uniform firm adhesions of the pericardium, and several cheesy nodules were found in the anterior wall of the heart, over the ventricular septum.

Typhoid Fever. Seven members of one family attacked at or about the same time.

Under the care of Dr. Robertson and Dr. Williams.

Reported by J. W. Barrett, M.B., Ch.B.

Resident Medical Officer.

The family consisted of a father, mother, and nine children, who landed in Melbourne on 1st June, 1882, and lived in Emerald Hill for a few weeks. About the end of June they removed to a cottage at the corner of River and Crown Streets, Richmond; that is on the Richmond Flat, close to the Yarra-bank.

The house is a weatherboard one, raised off the ground by piles of wood, and contains three rooms—two front bedrooms and one behind, a kitchen.
The front rooms are about 10 ft. high, 10 ft. long, and 13 ft. broad. In one there was a fire-place; in both windows, which were usually kept closed. There were no ventilators whatever.

The back room was 10 ft. high, 12 ft. broad, and 13 ft. long, and was imperfectly ventilated.

The mother, father, and one child slept in one of the front rooms, and the remaining eight children in the other. They entered the house on the 1st July, 1882, all being then in good health.

Seven out of the eleven developed typhoid fever, and nearly all had diarrhoea at first, with headache and weakness. Their food is said to have been of fair quantity and quality; the water Yan Yean. The closet attached to this and the one to the neighbouring house are destitute of any pan or receptacle, so that the fluid portion of the fecal matter runs about the yard, and soaks into the earth.

The ground in the neighbourhood of the house is flat and badly drained, collections of stagnant water existing during the greater part of the winter. There had, I believe, been no previous case of sickness in the house; but there had been several cases of typhoid fever in the neighbourhood.

Summary of the symptoms of these patients:

**Cases.**


4. Florence, aet. 10. Admitted 19th July. Ill 14 days, diarrhoea; bronchitis; high temperature—maximum 104·8° spots. Defervescence 24–27th day. Recovery.

6. Ernest, aet. 6. Admitted 19th July. Ill ten days or less; temperature never high. Defervescence seven days after admission; no diarrhoea, spots, nor abdominal symptoms. Recovery.

7. Annie, aet. 15. Ill seven days: most severe case. Great lung congestion; diarrhoea; albumen in urine. Temperature high and irregular; spots. Defervescence 28th day. Relapse on the 30th day; temperature again becoming very high. Complete defervescence 50–55th day. Recovery.

No. 6 case is interesting. It presented not a single symptom of typhoid fever, and if it had been an isolated case, would have been termed febricula.

In another family suffering from typhoid fever, admitted to the Hospital some time back, a similar condition was noted in two members, whilst the third had a most violent attack of typhoid fever, which made its appearance at about the same time as they (the other two members) were attacked.

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**Therapeutic Memoranda.**

An ounce of sweet spirits of nitre will dissolve 20 grains of quinia sulph. This makes a combination very efficacious in counteracting the troublesome nausea of fevers.—Dr. Kenner.

Soule’s Treatment of Seascickness.—R. Sodii bromidi ʒ iv., ammonii bromidi ʒ ij., aquæ menthae piperitæ ʒ iij. A teaspoonful before meals and at bedtime. Begin the treatment three days before going on board. Soule has no failure to record.

Dr. Andrieu’s ointment for soft chancres consists of one part of starch, one of pyrogallic acid, and three of vaseline.

For excessive sweating, bathe the body, a small surface at a time, with a sponge wet with the following lotion:—Alcohol 0 j, quinia sulph. ʒ i.—Dr. T. H. Currie.

P. B. B.
The fearful loss of life which attended the burning of the Ring Theatre in Vienna drew attention everywhere to the necessity for maintaining a constant watch over the construction and management of places of popular amusement; all our theatres are now supposed to be inspected from time to time, so as to ascertain whether the channels of egress are sufficient and unobstructed, whether every known precaution is taken against fire, and whether the means for quickly suppressing a conflagration are at hand.

The subject has been recalled to mind by the recent destruction of the great circus in Poland, when the terrible scenes of the Ring Theatre were only too faithfully repeated; and now we hear of a catastrophe in Nova Scotia even more pitiable, though the roll of victims is not so large. The Poor Asylum at Halifax caught fire on the night of the 6th November; "the flames appear to have spread with great rapidity, and soon cut off all escape from a part of the building which was occupied by the sick and infirm as a hospital. It is stated that over thirty of these unfortunate creatures perished in the flames." The Canada Medical and Surgical Journal, commenting on this deplorable accident, remarks that "it does certainly seem as though sufficient care and forethought had not been exercised in placing a large number of sick and infirm persons together at the top of a building, in rooms from which there were no adequate means of escape in case of fire. This is certainly a point upon which Government inspection ought to be most stringently brought to bear."

In this colony, too, especially in Melbourne, precisely the same conditions prevail; we have old-fashioned block hospitals and benevolent asylums piled up storey above storey, and even on the highest floors we find sick and bedridden patients. Take, for example, the central block of
the Melbourne Hospital; in the basement are the store-
rooms and quarters for the male attendants; on the ground
floor in the very centre are the offices of the secretary and
the apartments of the resident medical officers; above and
around these, flat after flat, are wards full of medical and
surgical patients; to encourage ventilation there are large
grated openings in the floors of the corridors leading direct
from the surface-level up to the roof. If a fire were to
break out at night in the storerooms or offices—and more
unlikely events might happen—most disastrous results might
ensue; the passages so useful for ventilation might furnish a
ready road upward for the flames, and the greatest difficulty
would be experienced in saving the disabled patients in the
topmost part of the building. Happily in the Melbourne
Hospital there are two separate staircases, one at either end
of the main corridor, and this of course largely diminishes
the risk; but still no precaution should be neglected. In
the Public Library and Museum, the staff are organised into
a fire brigade, every man having his distinct post and
function in any emergency; hoses and other appliances are
at hand, and thus every care is taken to protect the art
treasures of the colony. Surely it is time that some degree
of like attention should be paid to our block hospitals, for
otherwise buildings devoted to the relief of the suffering
poor may prove traps for a holocaust. At all events, we
would gladly hear that the city is provided with a sufficient
number of effective fire escapes, large enough to reach the
highest rooms in our hospitals and great hotels, and kept
unencumbered and ready for immediate service; and we
would remind the authorities that occasional fire-escape drills
would not be thrown away.
Extracts from the Medical Journals.

THE LANCETS.

November.

Mr. Rivington, of the London Hospital, concludes his very interesting series of cases of rupture of the urinary bladder. The sum of his remarks may be rendered thus:—He deprecates the sole use of constitutional measures as merely tending to promote the euthanasia. If any hope is to be entertained, it lies in the prompt application of efficient local treatment. The main indications are two—first, the removal of effused urine; second, the prevention of the escape of the urine through the rent in the bladder. To meet these, he recommends performing abdominal section first with antiseptic precautions, sewing up the rent in the bladder if it ought to be sewn up, and afterwards making an opening in the perineum, as in lateral lithotomy or cystotomy. "Doubtless the combined procedure may appear severe, but an intra-peritoneal rent in the bladder is a desperate injury, requiring to be met not by desperate but by thoroughly effectual measures, directed first to the removal of urine already extravasated and secondly to the prevention of further escape."

In some observations on the treatment of enlarged tonsils, Dr. Gordon Holmes does not counsel the operation of excision when the organs are in a state of acute or subacute inflammation, but agrees with the usual practice of waiting till the glands have regained their ordinary condition of chronic enlargement.

The use of the tonsillotome, especially Fahnstock's, in preference to Physick's instrument, is said to have almost superseded the bistoury and tenaculum, except in the rare case of a tonsillar calculus, in which the tonsillotome is inapplicable.

In rare cases after tonsillotomy (probably about 1 per cent.), haemorrhage is troublesome, requiring ice and strong styptics.

Dr. Holmes mentions an effective method of applying common caustics to the tonsils, which appears to have remained hitherto unnoticed. The tonsil is permeated by several rather large channels, around which the follicles are collected, opening on the pharyngeal side of the gland, whence its characteristic cribriform

NN
aspect. Their orifices, seven to fifteen in number, may be counted on the healthy tonsil in situ, whilst in the hypertrophied gland these laminae increase greatly in calibre and depth, varying from $\frac{1}{8}$th to $\frac{1}{4}$ inch long, and admitting an ordinary style. “Through these natural canals a way lies open for us to attack the heart of the gland in a most efficacious manner.” The galvano-caustic (a small loop of wire raised to a white heat by electricity) is an efficient measure. It certainly acts admirably in partial hypertrophies of the tonsil.

Mr. Le Page describes an apparatus for the operation of transfusion, by which he considers the disadvantages of Dr. Aveling’s method are overcome.

In a note to a case of aneurism of basilar artery, occurring in a boy of 16, reported by Dr. Hudson of the Leeds Dispensary, the main symptoms are set down as epileptiform attacks, fixed and persistent pain in the forehead, giddiness, with consequent sleeplessness, and intolerance of light.

Dr. Hughes Bennett discusses the differential diagnosis between hysterical paralysis and poliomyelitis anterior. The latter affection is better known as “infantile paralysis.” “The paralysis resulting from this serious organic disease of the cord attacks the adult much more frequently than is generally believed.” It is obvious that to make clear distinction between these two disorders is of the highest importance as regards treatment.

Dr. Bennett’s conclusions are briefly these:—1. That, judging from the history, symptoms, and progress of the case, in a large number of instances it is difficult or impossible to diagnose between paralysis from hysteria or from polio-myelitis. 2. The conditions of the reflexes afford valuable information. 3. That electricity supplies us with an agent which, in the large majority of cases, will definitely enable us to decide whether a given paralysis is due to organic disease of the anterior cornua of the cord or to that affection to which we apply the term hysteria.

In a paper read before the British Medical Association at Worcester, Mr. R. Dacre Fox, following in the footsteps of Wharton Hood, gives some valuable hints on the cases which bone-setters cure. He points out that these surgical irregulars are most successful with joints that have become stiff from enforced rest. Such joints should be “cracked up” without fear of consequences. “I am convinced that suddenness ought to be insisted on in doing this.” Mr. Fox strongly deprecates the manner in
which so many practitioners tamper with a sprained joint, and gives some very practical remarks on sprains. These injuries may be divided into two kinds, of which one consists merely of a temporary over-distension of the parts around a joint, which rest and anodynes soon cure; while the other involves pathological results of a much more serious nature. "A severe sprain is the sum of the injuries that the parts in and about a joint sustain, when by their passive efforts they exercise their maximum power of restraint to prevent luxation." The manipulative treatment of sprained joints consists in pressure over the part most injured, momentary extension of the limb, followed by sudden forcible flexion.

Prof. Chauveau, who is conducting an extensive series of experiments on puerperal septicæmia, has recently described the preliminary results he has reached. The animals selected were rabbits, who are very prone to suffer from the infection of puerperal septicæmia. "If the injection is into the peritoneum, a purulent infiltration forms in the skin around the point at which the needle perforated it. Death usually occurred in five or six days from the time of inoculation." Peritonitis, more or less, was always present, associated with double pleurisy and pericarditis, with much effusion containing large numbers of micrococci. If the animal dies in less than twenty-four hours, no peritonitis may be found, although the blood contains the infective micrococci in great numbers. Injection into veins causes no local inflammation.

R. A. S.

LONDON MEDICAL RECORD.

JULY.

Sweeting on Vaccination.—Referring to cases of small-pox occurring after previous vaccination, he writes:—"In proportion as vaccination is good, so is the severity of the attack mild, the case unaccompanied by complications, and recovery rapid, there being an almost mathematical progression as regards these points from the well vaccinated and the poorly vaccinated to the doubtfully vaccinated and the absolutely unvaccinated. Cases of other diseases sent to the Fulham Small-pox Hospital, and vaccinated on admission, did not take the disease; but they invariably did if vaccination was not performed. Unvaccinated cases of mistaken diagnosis, admitted by the medical officers as small-pox, were attacked with the disease at the usual period after admission.
Professor König, of Göttingen, in a lecture on the treatment of tuberculosis of bone and joints, asserts that surgical operation is the only therapeutical means from which we can expect a cure. By removing, antiseptically, only the parts that are diseased, a cure will result in most cases if the disease is not too extensive, and many a limb may be saved from amputation and many a joint from resection.

Ivanoff reports the case of a boy, aged 3, who swallowed twenty needles about two inches in length. Five days after, sixteen came away per rectum, embedded in faeces, and on the two following days the remaining four were passed one by one. There was no treatment and no symptoms, except an occasional pain in the belly.

Another case, this time by M. Greult, is given of a newly-born infant being saved from asphyxia by Le Bon's hot water treatment.

Dr. Vargunin's conclusions from his experiments on dogs would lead us to believe that Tappeiner has mistaken disseminated catarrhal pneumonic foci for tubercles in his investigations. Vargunin affirms that he succeeded in every case in producing these foci in the lungs of dogs by making them inhale organic particles, whether derived from phthisical, bronchitic, or normal sputa, or from previously disinfected cheese or flour.

AUGUST.

An article by Beetz on the treatment of scrofulous and tubercular affections by the inunction of various preparations of soap is well worth reading.

R. Koch having devoted his attention to disinfectants, finds that the only certain ones are chlorine, bromine, and corrosive sublimate, which are much more reliable than carbolic acid. The facile principes of germicides are the mercuric salts. Solutions of the sulphate, nitrate, or chloride, of 1 in 1000 to 1 in 15,000 are sufficient to kill micro-organisms. The poisonous action of these weak solutions is very little, and their cost is less than carbolic acid; they may therefore soon come into special use.

Dr. S. Sexton, writing on deafness in school children, suggests the examination of children as to their hearing, and placing those with impaired hearing in one or both ears in the most favourable position relative to the teacher for hearing his voice. The ability
to hear well should be a requisite in the appointment of every teacher. He examined 570 children, and found that 13 per cent. had defective hearing. He adds — "When no apparent cause for a child's dulness of action is known to exist, let there be made a thorough investigation into the condition of the acoustic organs before necessarily regarding it as a dunce or feeble-minded."

Bischoff relates a case of intra-arterial transfusion of an alkaline salt solution saving the life of a woman moribund from post-partum haemorrhage.

Rebatel, experimenting with pus from chancres and gonorrhoeal pus, could produce no effect with these on the mucous surfaces of dogs and rabbits.

THE MEDICAL RECORD (N.Y.)

Dr. Bodenhamer considers the opinion that horse-back exercise is a frequent cause of piles, and is prejudicial to the haemorrhoidal patient, to be erroneous. On the contrary "there is not a more certain preservative from piles than equitation," and when piles exist the pressure of the saddle, and the increased intestinal circulation produced by the shaking, exert a most salutary influence — relieving hepatic congestion and giving tone and elasticity to the lower part of the rectum. He finds that haemorrhoids are rare in cavalry soldiers, and in men who are habitually in the saddle, and quotes from Baron Larrey to the effect that soldiers compelled to mount and fight during an attack of hemorrhoids have found themselves cured when the conflict was over.

A proposed new remedy in cardiac affections is Convallaria Majalis, commonly known as Lily of the Valley, with which Professor Germain See has been experimenting. A drop of the aqueous extract of the leaves in contact with the exposed heart of a frog arrested its action in two minutes. Four drops injected into a dog's vein caused death in 10 minutes by arrest of the heart. The heart's action is first slowed; after a time it becomes irregular, and the pulsations faint and rapid; the blood pressure is first augmented, then lowered; respiration is first quickened, then becomes slower and slower till it ceases. The excito-motor power of the nerves and nerve centres is unaffected. Professor
Sée reports 20 cases treated with the drug. In five cases of mitral insufficiency, treated with half a gramme daily of the extract, the heart's action became stronger, the breathing easier, oedema disappeared, and there was a marked increase in the urine. Some cases of dilatation were also treated with marked success, and several cases of aortic disease relieved. In three cases there was no result.

He concludes that convallaria in doses of half to one-and-a-half grammes of the watery extract slows the heart, often with a restoration to normal rhythm, augments its energy and the arterial pressure, increases the inspiratory force, and especially causes increased diuresis.

It is indicated in all cases of cardiac disease indifferently, from the moment that watery infiltrations appear. In lesions with dyspnœa the effect is less marked. The drug has no deleterious effect on the system and has no cumulative action.

Dr. E. P. Hurd, who translates Professor Sée's paper for the Record, has tried the drug in two cases with success. He gave five drops of the liquid extract every four hours. Dyspnœa and angina were greatly relieved, and the urine was augmented.

A very exhaustive paper on Nerve Stretching is contributed by Dr. W. J. Chandler. After tracing its origin as far back as Wm. Fabricius, relating its accidental re-discovery by Bilroth, and describing the anatomical lesions and physiological effects produced by the operation, he gives statistics of 400 cases with a view to arriving at some conclusion as to its therapeutic value.

Of these 400 cases, 270 were cured or greatly improved; 58 were temporarily benefited, and 60 failed to receive any benefit. In 10 cases the result is unknown, and two cases were made worse by the operation. Of these 60 failures, 34 were in traumatic tetanus, and 11 in locomotor ataxia and diseases of the nerve centres. Removing these, we have 260 cases with only 14 failures, i.e., over 92 per cent. temporarily or permanently benefited.

Neuralgias seem to offer the most favourable field for nerve stretching, as of 70 cases, 68 were relieved; and "in idiopathic cases, and those, too, which have resisted all other modes of treatment, we must consider nerve stretching as one of the most effective remedial agents we possess."

In diseases of the nerve centres the results are not so favourable. 81 cases are recorded, 57 being for locomotor ataxia, with
33 per cent. benefited, 40 per cent. temporarily relieved, 25 per cent entire failures. 50 cases for traumatic tetanus were followed by recovery in 10 cases.

Dr. G. F. Shrady reports an interesting case of naso-pharyngeal tumour. It was diagnosed during life to be attached to the internal pterygoid plate, filling the left posterior nares, and possibly extending into the antrum, and also through the naso-palatine foramen into the spheno-maxillary fossa.

It was decided to operate, and remove the tumour by partial resection of the upper jaw. Laryngotomy was first performed and the pharynx tamponed. The jaw was resected by a modification of Maisonneuve's method, and the growth was then found to be attached to the basilar process of the occipital, the adjoining part of the body of the sphenoid, and temporal bones; it filled the superior vaults of the nose and pharynx, and extended towards the left into the pterygoid fossa. A portion of the posterior surface of the maxilla was absorbed, and through this the tumour extended into the antrum. An attempt was then made to separate the tumour from the basilar process by a raspatory, but finding a suspicious elasticity of the bone at that part, and fearing to injure the medulla, the tumour was then attacked on the left side with curved scissors and separated from its attachments, resulting in profuse hemorrhage. Three arteries were ligatured, the angular, internal maxillary, and sphenopalatine.

Death occurred from shock an hour after operating. At the autopsy, a fibrous tumour was found attached to the under surface of the left middle lobe of the cerebrum and resting on the foramen lacerum medium, being indirectly continuous with the nasopharyngeal tumour.

Dr. G. M. Sternberg communicates the results of some experiments as to the value of carbolic acid as a germicide. He found first that a 0.5 per cent. solution of carbolic acid failed to destroy the virulence of septicémic blood, and that the minimum amount that succeeded was 1.25 per cent. Next he found that the minimum amount of carbolic acid required to destroy the vitality of certain micro-organisms was also a 1.25 per cent. solution, a 0.5 per cent. solution also failing. He found a like coincidence in experimenting with iodine, and thinks it improbable that the virulence is independent of the living organism. Having thus determined the minimum amount of pure
carbolic acid required to prevent the multiplication of microorganisms, he gives a calculation of the amount required to prevent their multiplication in the blood of a man weighing 160 lbs., and finds it would be about 3 iv., rather a large dose, he thinks, as he reports a case in which 3 vi. taken for suicidal purposes produced marked poisonous symptoms, and nearly proved fatal.

G. A. S.

ST. LOUIS COURIER.

Dr. Steele treats Potts' disease of the spine between the fourth and eighth dorsal vertebrae by means of a plaster jacket extending from the point of attachment of the diaphragm to the ribs round the neck and thorax and over the shoulders. This while fixing the thorax and spine allows of free diaphragmatic breathing.

If the disease be above the fourth dorsal vertebra he applies a leather splint of the same shape, with a jury mast or chin-rest apparatus attached to the back of it, so that the weight of the head is borne by the thorax and shoulders. He removes this splint at night. Very clear directions for its manufacture are given.

Dr. Carson concludes a lengthy paper by asserting that—

(1.) Cysts of the broad ligament may contain an albuminous fluid.

(2.) Their fluids may contain 5 per cent. of solid matter instead of a trifling amount as stated.

(3.) Such fluids may present all the microscopical appearances of ovarian fluids, except that of the Drysdale corpuscle, whose existence in ovarian fluids is disputed.

(4.) Cysts of the broad ligament cannot be distinguished from ovarian cysts by any of the characters of the fluids they contain.

Caffein is recommended as a remedy for heart disease acting like digitalis but more powerfully. It is a diuretic, and must be employed in doses of from 5-30 grains.

An interesting description of the parturition of an elephant is given in this number. The calf was born with a caul, whereupon the parent broke the membranes and rolled the calf with its foot till it excited respiration. Then seizing a stake driven into the ground with its trunk it forced this powerfully against its abdomen to compress the uterus and expel the placenta.
The Pacific Medical and Surgical Journal contains the report of a case of aneurism by anastomosis of the upper third of the femur during the removal of which alarming haemorrhage took place. Also an account of the case of Dr. R. Beverly Cole, who some years ago whilst fasting was shot through the stomach with a large revolver bullet which entered at the junction of the seventh and eighth cartilages 1\(\frac{1}{2}\) in. from the midline, and appeared under the skin over the 11th and 12th ribs behind. He fainted, but during reaction vomited half a gallon of blood. He recovered after a tedious illness, and is now thought to owe his life to the fact that his stomach was empty when he was shot.

J. W. B.

CANADA MEDICAL AND SURGICAL JOURNAL

Nerve Stretching in Sciatica.—Dr. Stewart reports three cases in which this operation was performed antiseptically with partial or complete success, and another case in which the same nerve was stretched for the relief of a painful stump with equally good result. Dr. Chandler, of New Jersey, has collected seventy cases of sciatica treated in this way; 97 per cent. were cured or relieved; but at least five fatal cases have been reported, death being attributed to chloroform in three of them. It appears that with ether the utmost stretching of the nerve does not depress the pulse more than four beats per minute, but with chloroform a reduction of 40 beats has been effected almost instantly. Hence ether should always be used in these operations.

Dr. Smith, of Ontario, reports a case of hydatid of the lung successfully treated by incisions and drainage, with daily injections of tincture of iodine and water, 1 to 4 and sometimes even 1 to 2.

From the Montreal General Hospital come notes of a case of intense chorea, proving fatal in ten days, a few soft vegetations being found on the mitral valves after death; also of a man aged 29, previously robust and hardworking, who was admitted with acute suppurative inflammation of the hip joint and died of pyaemia.

Artificial Membrana Tympani made of Elastic Collodion.—Dr. S. Pollak obtains excellent results by following Krause's method, instilling three drops of glycerine of tannic acid (two
grains to the ounce) into the tympanum, and then three drops of
elastic collodion upon that. A new membrane can thus be formed
in ten minutes, strong and solid, and with most satisfactory
influence over the hearing.

The "Bacillus" Theory of Phthisis.—From the "Michigan Medical
News" it appears that Koch's theory does not meet with anything
like unanimous acceptance in the States. At a meeting of the
Philadelphia Medical Society, when Wood, Gross, Tyson,
Bartholow, Cohen, and others spoke on this subject, "none of
the speakers seemed to have adopted Koch's views."

Resection of the Intestine.—Dr. Wm. Fuller reports in the "New
York Medical Record" October 14th, three cases of partial
intestinal resection for strangulated hernia; recovery took place
in all.

Fracture of the Odontoid Process.—In a recent clinical lecture at
the University of New York, Professor Smith exhibited a patient
with probable fracture of the odontoid process; the patient in
December 1881 fell from a height upon the deck of an ice barge,
and struck on his neck; he was taken to the Hospital and found
so paralysed that he could not sit up in bed, and quiet was insisted
on. He gradually gained more and more use of his limbs, and his
head became firmly fastened to his neck with the chin bent
downwards upon the chest, and so rigidly that he could not move
his head from side to side, or up or down. On introducing a
finger to the back of the mouth, the atlas could be felt projecting
forwards. The patient was kept sitting in a chair with a cross
piece behind him, to which his head was bound so as to steady it.
He gradually improved and could walk around the wards without
his head becoming loose, and at the time of the lecture he could
even run a little. There was marked thickening of the joints of
the fingers and permanent contraction of some of the muscles.
The lecturer quoted a case from the practice of Dr. Parker, in
which a milkman was thrown from his waggon on to his head;
he got up, but found his head quite loose, so that he could not
hold it up nor turn it from side to side; he steadied it as best he
could with his hand and then got into his waggon and drove home
again. After some days he consulted Dr. Parker, and finally was
able to resume his business, but six months later, after a hard day's
work, he suddenly fell dead at the table, his head dropping forward
on his chest. The specimen of the fracture was preserved.
Professor Smith narrated another case which occurred in his own practice five years ago, with similar history:—a fall on the head, immediate looseness of the head, rest for three or four days, subsequent return to work as a carpenter, then gradually paralysis set in, with progressive emaciation, the head being thrown back and fixed and the chin thrown out. After death the odontoid process was found fractured and the atlas displaced forwards. —(from the Medical Gazette and Western Medical Reporter.)

Bacillus Tuberculosis.—To display the bacillli in phthisical sputum, two colouring fluids are required, some nitric acid, and a Bunsen’s jet. The first staining reagent is prepared by mixing aniline oil with distilled water, and allowing the mixture to stand for four or five hours at least, with occasional agitation; then add to 100 grammes of this fluid, 11 grammes of concentrated alcoholic solution of methyl violet powder. The decolorising solution is nitric acid (German pharmacopoeia), one part, to distilled water, two parts by volume. The final staining is a concentrated aqueous solution of vesuvin, recently filtered, but still quite thick. Spread a little sputum as thinly and evenly as possible over a coverglass with a knife, fix it by passing the glass, specimen side up, two or three times through the Bunsen’s jet, so as to dry it without burning; half fill several watchglasses with the methylene dye, and invert the coverglass upon the surface of the solution; here the specimens rest for half an hour; then lift the coverglass, shake off the superfluous colouring fluid, and immerse the whole in the diluted nitric acid, moving it about till the colour disappears; wash away the superfluous acid, and then let a drop of the solution of vesuvin fall upon the coverglass while it is tipped about so as to diffuse the colour all over the field; then press the coverglass upon a slide and commence the examination. The bacillus is rod-shaped, varying in length from $\frac{3}{1200}$ to $\frac{1}{300}$ inch, it is absolutely motionless, produces spores, 2 to 4 in the body, and is blunt at both ends. It is best to prepare several specimens, for you may fail to find bacilli in any one.—(Professor Whittaker’s lecture and demonstration before the College of Physicians of Philadelphia. Medical News and Western Medical Reporter.)
The University of Melbourne.

ORDINARY EXAMINATIONS—OCTOBER TERM, 1882.

PASS LISTS.

First Year Medicine.


Second Year Medicine.


Passed in Subjects Entered for.


Practical Chemistry.


General Anatomy, Physiology, and Pathology.


Descriptive and Surgical Anatomy.


Materia Medica.

J. G. Wilson.

Third Year Medicine.


Passed in Subjects Entered for.

J. B. Donaldson.

Fourth Year Medicine.


Fifth Year Medicine.


Degrees Conferred.

Bachelors of Medicine.


Bachelors of Surgery.


Ad Eundem.—Doctors of Medicine.

Thomas Rowan (Sydney), David John Williams (St. Andrew's).

New Professorships.

The following gentlemen have been appointed to the Professorships recently created in the University:

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<tr>
<th>Subject</th>
<th>Professor</th>
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<tr>
<td>Modern Languages and Literatures</td>
<td>Mr. E. E. Morris</td>
</tr>
<tr>
<td>Anatomy and Pathology</td>
<td>Dr. H. B. Allen</td>
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<tr>
<td>Chemistry</td>
<td>Dr. Kirkland</td>
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<tr>
<td>Natural Philosophy</td>
<td>Mr. H. M. Andrew</td>
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<tr>
<td>Engineering</td>
<td>Mr. Kernot</td>
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With the exception of Mr. Morris, all the new Professors have previously acted as Lecturers on their respective subjects in our University; Professor Kirkland and Professor Kernot in especial having been so engaged for a long term of years.

ALTERATIONS IN THE MEDICAL CURRICULUM.

Botany has been transferred from the second to the first year; the Physiological courses have been altogether re-arranged, so that in future the second year's studies will include Physiological Chemistry and Histology, with lectures, demonstrations and laboratory work, while Physiology proper will come into the third year's work; lectures on Pathology are made compulsory in the fourth year, and every student must attend post-mortem demonstrations for six months in the fourth year, and for a like term in the fifth; the requisite number of labours, too, which must be attended, has been very properly raised from twelve to twenty.

CLINICAL TEACHING.

The Council of the University recently requested the Committee of the Melbourne Hospital to appoint one Physician and one Surgeon as Clinical teachers; but the Committee rightly decided that any such appointments must be made by the University itself; the whole question therefore stands over till next year.

THE MELBOURNE UNIVERSITY.

At its ordinary meeting on the 4th inst. the University Council made appointments to the new Professorships of Anatomy, Chemistry, Engineering, Modern Languages, and Natural Philosophy. All the gentlemen so promoted are well known, and the University is to be congratulated on having permanently secured their services as teachers. To us, as medical men, most interest attaches to the appointment of Dr. Allen to the Professorship of Anatomy and Pathology, and of Mr. Kirkland to that of Chemistry. Of Professor Allen little needs to be said in this Journal. To some of its readers he was known as a student of brilliant promise, and all of them know how well that promise
has been fulfilled. In his new position there will be room for a full display even of his zeal and energy, and those who have watched his career confidently anticipate that what he has already done is but an earnest of what is yet to be accomplished for the furtherance of scientific medicine in Victoria. Professor Kirkland has been comparatively little before the public; but those who have studied under him can testify how zealously he has wrought in the lecture room and laboratory, and how valuable his teaching has been from its practical character.

J. J.
Local Subjects.

APPOINTMENTS.—The following gentlemen have been appointed officers of health for the districts named:—Boroughs—Hamilton: George Annand, M.D., vice M. W. Chambers, resigned; Inglewood—Alex. Adam, M.B., vice W. E. Le F. Hearn, resigned; Maryborough—James Campbell, M.D., vice C. Dixon, resigned. Shires:—Ballarat—Sigismund Zichy-Woinarski, M.B.; Caulfield—John Anderson Irwin, surgeon; Oxley—Wm. H. Macfarlane, M.B.

ELECTION FOR THE MELBOURNE PROVINCE.—The election of a member of the Legislative Council for the Melbourne Province was held on 30th November. Mr. Ham, the successful candidate, polled 2805 votes; Dr. Beaney, who stood in the Liberal interest, polled 2698; and Mr. Coppin, who split the Conservative vote with Mr. Ham, received 2148. Dr. Beaney's campaign, though unsuccessful, is known to have been very expensive. His advertising was simply phenomenal.

ACCIDENT TO DR. YOUL.—Our readers will regret to hear that the City Coroner, Dr. Youl, sustained a severe fall about a week ago, which caused a simple fracture of the fibula into the ankle joint. We are glad to hear that he is doing as well as can be expected.

BIRTH.


MARRIAGES.

ANDERSON—SIMPSON.—On the 13th November, at the Leigh Church, Shelford, by the father of the bride, assisted by the Rev. J. R. Anderson, M.A., of Penshurst, Dr. Anderson, of Urana, New South Wales, to Margaret Gardiner, youngest daughter of the Rev. A. Simpson.


DEATHS.

FRASER.—On the 19th November, at his residence, Cheltenham, Henry, fifth son of the late James Fraser, M.D., Limerick, Ireland, in the 65th year of his age. Home papers please copy.

ROBERTSON.—On the 9th December, at her residence, No. 4 Hepburn-terrace, George-street, East Melbourne, Jane, relict of the late Alex. P. L. Robertson, M.D. of Kew, aged 62 years.

PUBLICATIONS RECEIVED.

The usual exchanges have been received.
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