A CASE OF FIBRO—MYOMA AND INCOMPLETE RETROFLEXION OF GRAVID UTERUS.

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On December 16th, 1889, I was sent for by Dr. James, of Heidelberg, to see a patient who was in labour, and in whom he had diagnosed a retroflexed uterus.

I reached the patient, M. B., about 11 a.m., and was informed that she was 36 years old, had been married ten months, that the date of last catamenia was uncertain, but she believed herself "at full time," and had engaged a skilled midwife, who had been in attendance two days. The nurse informed me that true labour pains commenced at noon on December 13th, and the membranes had ruptured at 7 p.m. on the 14th. She had given an enema; but, being unable to reach the os uteri, and experiencing some difficulty in withdrawing the urine by catheter, Dr. James was called in, and had formed the above-mentioned opinion. The patient was in bed, evidently in labour, with regular, feeble pains, and looking very thin, pale and exhausted; her pulse 110, and weak.

On inspecting the abdomen, it became evident at once that it was unusually small for a utero-gestation of nine months, but she was certain that she had only menstruated once, about a month after marriage. The fetal parts were distinctly felt through the thin abdominal parietes, and the heart was heard beating 130 to the minute, low down in the right iliac fossa. The uterus did not reach more than three inches above the umbilicus, and at its upper and anterior extremity a non-pedunculated fibroid could be felt, about the size of a hen's egg. The measurement between the iliac crests was 7¼ inches.

Dr. James administered chloroform, and a careful examination was made. The vagina was short, dry and hot. The finger impinged on a hard conical tumour, the apex of which was blunted and directed downwards and backwards, while over it the posterior vaginal wall freely moved. Then, with some difficulty,
another tumour could be differentiated from this, higher up, very much larger, and less hard than the first—to which it was attached. Both entirely filled the pelvis below the sacral promontory, which could not at present be reached. Following the larger tumour upwards for about two inches above the pubic arch, I managed to reach the thin edge of the external os, which was directed forward, and dilated to the size of a shilling; the cervix was not entirely obliterated. I concluded that the first object reached per vaginam was a fibro-myoma of the fundus uteri at its lowest part, and that a portion only of the fundus was retroflexed, containing the head of the fetus, while the trunk was lying obliquely in the maternal pelvis. No presenting part whatever could be reached.

It was evident that the fibroid was extra-mural, and by its dependent position prevented the fundus from lifting, and practically blocked the conjugata vera, so that its diameter was lessened by three inches. For I could not even pass two fingers between it and the symphysis pubis. Using a Chambers' hook, guided on my fore-finger to the os, and by pushing up the fundus per rectum, I managed to draw down the os, and gradually inserted a small-sized Barnes' bag, and filled it with water. I then tried all I could think of to replace the retroflexed portions. The patient was placed in every position suitable—the genupectoral, on her hands and knees, and with the pelvis alone raised. The most promising attempt consisted in using one hand in the rectum, and making counter pressure and guidance with the other on the breech through the abdominal wall, to try and get the lower and retroflexed part into the oblique diameter. This raised it very slightly; every attempt, however, being frustrated by the fact that the fibroid always caught under the sacral promontory.

All these movements, which had to be most carefully done, occupied nearly two hours, and we agreed to give the patient an hour's rest, some food and stimulant. I examined again, about 2 p.m., only to find—to my chagrin—that the Barnes' bag had slipped out, and that the right elbow presented through the os, which was as high as before. The patient was placed under ether, and I sought to find some method of replacing the elbow, but absolutely no improvement was made. I could get no further into the os; could therefore find no part of the fetus suitable to assist in turning, craniotomy, or evisceration; neither did the nurse, who had a very small hand, nor Dr. James do more
than touch the os, even when pulled down by the volsellum, upward pressure being exerted (per rectum) on the retroflexion. Therefore, after careful consideration, and seeing that the patient was exceedingly exhausted, it was agreed that Caesarian section should be performed as soon as possible. The uterine pains were absent, and although the child was felt to give a few feeble kicks, the fetal heart could not positively be heard.

While Dr. James and myself were making the necessary preparations and another room was made ready, the patient rested, and stimulants were given. As the light would soon be waning, we were obliged to commence at 5.30 p.m. The abdomen and pudenda had been washed with solution of perchloride of mercury (1 in 3000). Dr. James administered ether, and I had the advantage of the very willing and efficient help of his assistant, Mr. O'Flaherty. We had also a well-trained nurse, besides the midwife, and, as it proved, every one had plenty to do. The first incision extended from an inch above the umbilicus to the same distance from the symphysis. The uterus was lifted entirely out of the abdominal cavity, and, as we had no ligature, Mr. O'Flaherty exerted firm pressure with both hands, by clasping the cervix. The incision through the uterus—a longitudinal one of five inches—was followed by the most severe haemorrhage I ever witnessed. The placenta was situated centrally and superiorly, and untouched by the knife. The child was quickly extracted by the breech, but only gave one gasp. There was considerable difficulty in extracting the head, which was firmly wedged in the retroflexed portion. The haemorrhage was still profuse, and the uterus did not contract as quickly as I have seen it do in similar cases. The placenta was firmly adherent, and had to be slowly peeled from its insertion. Plain hot water was now injected into the cavity of the uterus, and contraction ensued. Three fibroids were seen, an upper one that had been felt by abdominal palpation, a lower one (felt per vaginam), and one that was clean cut through by the uterine incision.

The patient was pulseless, and all haste was made to complete the operation. Fortunately, neither omentum nor intestines gave any trouble. A continuous suture of kangaroo tendon was used for the uterine wound, interrupted silver and silk for the peritoneum and abdominal. Before closing the uterine wound, the cavity had been well cleaned with sponges, and attention had been given to the patency of the cervical canal.
The abdominal cavity was thoroughly flushed with warm water. No drainage tube was at hand, nor strong tourniquet for the cervix, as advised by Lawson Tait.

A wedge-shaped piece of muscular tissue was removed from either side of the uterine wound, otherwise the cut fibroid would have prevented accurate apposition.

The whole operation lasted 35 minutes, and the patient rallied remarkably well.

Despite constant medical attendance and excellent nursing, she gradually became weaker, and died on the 19th inst., 71 hours after the operation.

Although there had been pain and some vomiting on the 18th, yet the abdomen was quite flat, the wound dry and healthy, and there was ordinary scanty lochia per vaginam.

No post-mortem examination was obtained.

Remarks.—On enquiring into the history of the case, I find that, for many years, the patient had suffered from dysmenorrhea and constant backache, but without any floodings. Probably, therefore, retroversion existed up to the time of her marriage; and notwithstanding the absence of hæmorrhage, we are justified in attributing this condition to the presence of those growths which were afterwards revealed by the operation. Assuming this to be correct, the sequence of events included impregnation, enlargement of the lower part of the fundus uteri, tilting backwards of that part from the ring of Bandl, and the consequent establishment of incomplete retroflexion. This condition, once established, was maintained, and the fundus was prevented from rising out of the pelvis, by the combined weight of the growing fetus, and of the fibroid on the posterior wall, stimulated to increased growth by the augmented blood supply. Hence the continuance of gestation in the uterus thus abnormally placed.

This case is one to which I have found no exact parallel in my reading or experience. The chief points of interest are the following:—

1. The occurrence of impregnation, immediately after marriage, in a uterus affected with retroversion and a fibroid tumour.

2. The rare condition of incomplete retroflexion of the gravid uterus, associated with the presence of a myoma. Spiegelberg states that thirty cases of incomplete retroflexion are on record, in which Cesarian section was performed, and that of these, four women and eleven children were saved. Tarnier had one
unsuccessful case. Haultain has lately reported a case of retroflexed gravid uterus, in which death resulted from sloughing of the posterior wall of the bladder, due to pressure.

3. The continuance of gestation to full term, and the absence of vesical troubles. In such cases, the uterus usually empties itself at the third or seventh month, either because its further enlargement is mechanically impeded, or because constant haemorrhages, due to obstructive congestion, induce abortion.

4. The question whether, after labour had already lasted two days and a half, I was still justified in deferring operation, and attempting to reduce the displacement. This point I fully considered, and I believe now, as I did then, that the patient was entitled to every legitimate endeavour for her relief before the dernier resort of Cesarian section was undertaken. For some time, indeed, until the elbow presented, there was a reasonable hope of delivery per vias naturales.

The accompanying diagram, modified from Spiegelberg to illustrate the case, represents the position of the foetus when I first saw the patient.

INAUGURAL LECTURE, MELBOURNE HOSPITAL CLINICAL SCHOOL, SESSION 1890.

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Following the praiseworthy custom of most English medical schools, we this evening inaugurate a new year of work with an introductory address. Some preliminary personal explanation, however, is necessary, as to how it has come about that this honorable and onerous task has been entrusted to my hands, when there are so many who are still my seniors, and have been my teachers, who could have filled the position with far greater appropriateness and success. This is the third year during which there has been the present explicit understanding between the University and Hospital upon the question of clinical instruction. Owing however to unforeseen delays at its inception, last year proved the first upon which such an introductory lecture as the present was possible; and it will be within the recollection of all how well Mr. James then delivered the first inaugural address ever delivered in our Clinical School. This year it naturally fell
to the lot of the physicians to supply the lecturer, and owing to
the unfortunate absence or inability of my seniors to act in that
position, the responsibility had to be placed upon me, and I have
felt it a duty, as well as a very great honour, to obey. I need
hardly say, however, how thoroughly I share your regret at being
deprived of the pleasure of listening this evening to words of
wisdom from such old and tried members of the staff as Drs.
Moloney, Williams, and MacInerney, and I can only hope that if
in manner or matter I fall too far short of the high level to which
they would have attained, you will grant me your indulgence,
remembering that the time at my disposal for preparation has
been most limited, and that my task is no ordinary one.

It has generally been found difficult to select a topic fitting for
such an address as the present. For instead of dealing with some of
the many orthodox questions wherein choice is always easy, and
generally fresh, your lecturer must discover and discuss some
important matter of general interest; and such matters are not
only comparatively rare, but soon become hackneyed. Fortunately,
however, for me, our series is only just beginning, and there
remains still untouched a theme which I venture to think meets
all our requirements to a degree which merits its selection this
evening—I refer to the history and position of our Hospital as a
Clinical School. Before entering therefore upon the few words of
welcome and advice to students with which such lectures as this
may be always fitly closed, I purpose trespassing—I trust not
unduly—upon your patience with a suggestive, if incomplete,
review of the past history of our Clinical School, with a brief
resumé of its present position, and with a few hints as to its
present needs, and the direction of its future expansion.

The past history of our Clinical School has for all of us an
interest which is even more than personal. For not only has it been
the training ground of all our past medical students, but in
its development and relation to the University it presents a
most interesting illustration of growth, modified by our peculiarities in environment. This modifying factor, indeed, is the key to
the understanding of our clinical position. For from its birth
onwards, our Melbourne Medical School has differed from
both its great exemplars—London and Edinburgh. It is certainly
ture that in all three alike there is a University or College,
which formulates a certain curriculum of study, and finally
examines candidates thereon. But, whilst the University of
Edinburgh has associated with it a hospital, of whose staff its medical professors are *ex-officio* members—so highly paid that private practice may be made a matter of no consequence; and whilst the University and Colleges of London, on the contrary, have no such affiliated institution, but leave all teaching, systematic as well as clinical, to be undertaken by outside and independent bodies—the great London Hospitals—our Medical School follows Edinburgh in retaining control over all systematic instruction, but finds itself compelled to follow London in leaving all clinical training to such general hospital or hospitals as might be available. That either the Scotch or the London plan alone will be successful, if properly carried out, has been proven by the very high position which each of these Schools has gained in the opinion of all Anglo-Saxon communities. The problem which we have had to solve, however, has been—what measure of success could be gained from such a mixed plan as ours? And the answer has, to some extent at least, been foreshadowed by our experience during the past few years. And, believing as I do, that in Edinburgh the high pitch of excellence attained in teaching, is somewhat discountenanced by comparative paucity of material, and consequent diminution in practical experience; and that in London the greater facilities and opportunities for work are, to some extent, counter-balanced by a noticeable weakness in the systematic courses, I am one of those who venture to think, that at no distant period our Melbourne Medical School, in its different circumstances, may hope to combine something like the comprehensive teaching of Edinburgh with some measure of the greater practical experience of London. It is, in my opinion, therefore, a good thing that our University has, like that of Edinburgh, retained complete control over the systematic and non-clinical portions of our course. The restriction of tuition in a few official hands, which necessarily followed such direct responsibility, has proved sufficient for all our requirements, within the scope of our limited University means, and productive of the best all round results. And upon these grounds alone, to say nothing of others which might be advanced, it might be satisfactorily argued that the continued retention of such control in University hands is the plan which will best advance the interests of our School. But with reference to the clinical portion of our course, in which our position resembles rather that of the London Schools, difficulties have always been present, such as have been unknown in their happier experience. Thus, for many years,
instead of many emulous institutions, we had but one general hospital—the Melbourne Hospital—suitable for University purposes; and instead of a strong traditional bond between the two, it is, even yet, no part of our Hospital charter to teach students at all. Further, for many years, the University having much to do in the direction of developing its own curriculum, and having no right to intrude, left Hospital questions severely alone, simply requiring a certain amount of practise without seeking to know much as to how that practice was gained. True, the Hospital made bye-laws to allow such practise, and even strained its powers somewhat to enjoin upon its staff clinical instruction as a duty. But as the staff were in no way encouraged or recognised by the University, and as no outside rivalry existed to incite to systematic effort, matters were left very much to the good-will and kindly feeling of individual members. And a deep debt of gratitude is due to those who in those early days gave freely of their time and talents, and helped onwards the students who would otherwise have had to help themselves. In course of time, however, owing to the growing importance of the School, a closer connection between Hospital and University became imperative. In its new curriculum, the latter made its requirements both more extensive and more specific, and the questions had to be settled how to meet these fresh requirements, and how to ensure their efficient fulfilment. It was but natural that opinions should be divided upon such a point. Two parties arose. One—recognising that the University had no control over the Hospital staff, and that future staffs were to be elected simply by Hospital subscribers—desired to follow the Edinburgh plan, and appoint two or more clinical lecturers, with the status and pay of other University lecturers, leaving the rest of the Hospital staff and material just as they found it. The other—recognising that in the past the Hospital staff had admittedly fairly represented the best professional skill of the metropolis, and that Hospital rules had been framed which would restrict candidature for the future to those holding qualifications at which the University could not cavil; and recognising also that the establishment of a Clinical School at the sister Hospital had altered the whole position of affairs, and combined with internal reasons to give satisfactory guarantees as to efficiency—advocated the London plan of formulating requirements, and leaving it to the Hospital to make its own arrangements, subject to the approval of the University.
The latter party pointed out also that by this means the whole of the Hospital material would be rendered available; that the establishment of sister schools became possible, without ruinous expense to the University, and that the guarantees of efficiency which had grown up in London were rapidly being evolved in our own case. The contest was long and strenuous. At first the University tried the elective plan, but after two years' experience, and upon the recommendation of a sub-committee appointed for the purpose, it adopted the London system. In 1887 this arrangement came into force for the first time, and it has been continued ever since. The result already, has been that two Clinical Schools exist, each an incentive to the other, that, in our own case, the whole staff, with two regretted exceptions, have combined to carry out the requirements of the University, and that the Medical Superintendent has each year been enabled to report that more and better work has been done in all departments than had ever been done previously. And here it is only right to mention how fully the Hospital committee (who have supreme power in these as in all matters relating to Hospital usage), have recognised their share of responsibility in this important work of medical education, have met the staff and the University half-way in this matter, and have throughout cordially supported this closer bond of union. And that the University may understand how intent the staff also have been upon the performance of their part of the contract, it is only fair to point out, not only that the actual results achieved have been reported upon so satisfactorily, but that by defining terms, settling questions of work and pay, and formulating all the necessary machinery to the satisfaction of the University, the staff have placed the whole scheme upon such a sound basis that future friction is rendered almost impossible, and that they have every confidence in looking forward and in anticipating an improvement with each successive year.

But the past record of the Hospital, as a Clinical School, merits fuller recognition The history of our Medical School, indeed, is indissolubly bound up with the history of the Melbourne Hospital, and the honours which are everywhere showered upon the one, must fall to some extent upon the other also. Since the year 1865, when P. Moloney and W. C. Rees entered it as the first two medical students, our School has grown by leaps and bounds, until at present, the number of students attached to it is 130. Within its walls have been trained some 200 graduates in medicine and
surgery. Its list of old students includes one University Professor, one Ex-Professor (the lamented Professor Kirkland), and one Acting Professor (all entirely locally trained), one Lecturer, and one Acting Lecturer. It has given to the University Senate, four Masters of Surgery, and more than twenty Doctors of Medicine. Of our Resident Medical Officers, no less then 69 have been locally trained, and both the late and the present Medical Superintendents (Dr. Lewellin and Dr. Molloy), are ex-students. Of the present Honorary Staff, two In-Patient Physicians, four Out-Patient Physicians, and four Out-Patient Surgeons are all included in the same category. And there is scarcely a hospital of note in the Australasian colonies, whose staff has not been largely recruited from old Melbourne Hospital students. Outside officialdom again, the Hospital has shared with the University in providing the profession with many of its brightest and most respected members, whilst some of its old students have successfully competed even for the highest home qualifications for which they were eligible. We have every reason, therefore, to be proud of the roll of old Melbourne Hospital students.

A more important matter, however, for us is our present position as a Clinical School. The nature of our arrangement with the University has been already discussed. It still remains, however, for me to explain for outside benefit, what are the University requirements, and how we expect to carry them out. Briefly stated then, our provisions for the instruction of students during the coming year are as follows:—The second year students will attend the practice of, and receive instruction from, the out-patient surgeons—Drs. Webb, Syme, Moore, and Bird. They will also attend casualty and dental practice. The third year students will attend the practice of, and receive instruction in the methods of examining patients from the out-patient physicians—Drs. Annand, Grant, Howard, Fletcher, and Joske. They will also act as junior ward clerks to Drs. Astles and myself, and be trained in the principles and practice of medical diagnosis. The fourth year students will act as surgical dressers to Drs. James, FitzGerald, Beaney, and C. Ryan, and attend a course of clinical lectures delivered by at least three of those gentlemen. The fifth year students will act as ward clerks to Drs. Moloney and Williams, and attend a course of clinical lectures by those gentlemen, as well as by Dr. Astles and myself. In addition, the skin depart-
ment under Dr. Stirling, and the post-mortem department under Dr. Mollison, will be open to students, and arrangements are made for regular instruction therein. The Medical Superintendent, Dr. Molloy, will act as registrar and see to the proper carrying out of all details, and the Resident Staff will give such supervision and instruction as their time will permit.

And turning to the clinical material at our disposal, upon which of course the value of all our arrangements depends, examination shows it to be both sufficient in quality and representative in character. Here, indeed, we have one of the strongest points of our school. A few statistics may be permitted. In 1888, the daily average of in-patients was 270, and of out-patients 156; whilst in the Dental Department, 1274 cases were treated. During the same year, 746 deaths occurred, and upon a large proportion of these a post-mortem was made. Taking the total number of students as 130, it may fairly be claimed that our students have a perfect wealth of material at their disposal, whilst they are free from that overcrowding which has become so characteristic of almost all British schools. This is well seen in the case of the senior students. Thus, last year there were twenty-four fifth year students attending in-patient medical practice, and for nine months they acted as ward clerks, and had eighty-nine beds at their disposal. The same might be said of the surgical dressers. And equally, if not more valuable to the student, is the fact that our material mirrors, in a manner which cannot be surpassed, all phases of Victorian accident and disease. This can be best seen by a perusal of the statistical statement appended by Dr. Lewellin to the Annual Report of 1888 (which is the last that is available). Thus, to take only a few examples by way of illustration, I find that in 1888 there were treated in the Hospital 353 cases of typhoid fever, 169 of rheumatic fever, 191 of heart disease—including 21 of aneurism, 279 of phthisis, 196 of nervous disease, 20 of hydatids, 124 of venereal diseases, 340 of digestive diseases, 289 of respiratory diseases, 101 of urinary diseases, 38 of gout, and 47 of cancer. And surgically, there were admitted no less than 679 cases of fracture, and 118 of gunshot wounds, whilst 346 principal operations were performed; and our out-patient department has been truly styled the common meeting place for every sort of disease with which our metropolis is acquainted. And when we consider these facts, and remember also how inheritance and environment
modify our disease, so that in incidence and form it differs largely from that prevalent in the old country, there is little need for me to emphasize, not only the intrinsic value of our Hospital as a Clinical School, but the special importance of future Australian practitioners learning the practice of their profession in the land in which they are to live, instead of spending their student days, as has been too much the custom, in other climes, and under different conditions.

It must not be thought, however, that we are perfectly satisfied with our present position. Though thankful that a good deal has been done, and that more is on the verge of fulfilment, there are still many improvements which we desire to see in the Hospital itself, in the scope of its work, in our own arrangements, and in the University curriculum.

The views of the staff upon the Hospital itself, apart altogether from clinical considerations, are too well-known to need elaboration. As far back as November 1885, we addressed a letter to the managers, earnestly impressing upon them the necessity of preparing a general plan of re-construction upon a larger scale, either on the present site, or elsewhere, a majority of the staff being strongly in favour of removal, as well as re-construction. It is the question of site, indeed, which underlies all reform. That something, however, has been done in the direction of improvement, may be candidly admitted. Thus, the mortuary has been re-constructed, the nurses better housed, tents established for infectious cases, and excreta suitably disposed of. But the general plan of re-construction, which has ever since been strenuously urged, remains still upon paper; owing mainly, in my opinion, to the want of settlement of this question of site.

I take it for granted now, however, that the committee do not intend to remove the Hospital, and much as most of us regret such a decision, I for one am prepared to accept the inevitable, and join in working for the pressing reforms which are thus possible. The matter becomes now simply one of funds, and I am confident that the public, who so generously subscribed £10,000 within a fortnight, to pay off our Hospital debts, will respond when asked, to put this noble charity upon a satisfactory footing.

I have been permitted to see plans of the proposed alterations which the committee now intend. The committee propose, almost immediately, to pull down the present refractory wards,
to enlarge the casualty room, to construct several additional consulting and waiting rooms for out-patients, to re-construct the operating theatre, and to attach to it a proper lecture room. These represent immense advances, which will double our efficiency as a school. Later on, it is proposed to pull down the centre building, and the east and west wings, and to erect pavilions in their place, whilst fresh pavilions are to be built between the present buildings and the Lonsdale-street frontage. When this is accomplished, we will have a Hospital upon the present site, containing some 400 beds, and built according to modern ideas.

Not the least valuable feature about this proposed plan of re-construction to us, of course, is the fact that it will render possible that addition of special departments to the Hospital, without which it can never become a thorough Clinical School, and for which the University is already asking. As far back as 1885, the staff pointed out the advisability of appointing an oculist to the Hospital; in 1887, other special departments were added to the list; and in 1888, when the University Council wrote, asking what facilities the Hospital could afford for teaching its students in these special branches of practice—branches with which they must be familiar, if they are properly to discharge their duty towards their patients—both committee and staff united in expressing their willingness to afford such facilities as soon as the fresh appliances, increased accommodation, and augmentation of staff thus necessitated, could be provided for. The Hospital, therefore, is pledged to such widening of the scope of its practice, and indeed, makes provision in the proposed plan of re-construction. We have every reason to hope, therefore, that the present year will not end before some, at least, of these necessary departments have become actually attached to it.*

Nor are we as a staff, quite satisfied with the curriculum under which we have to work. Our main complaint is, that so many students come down to the Hospital unable to appreciate the instruction which is to be given to them. A second grievance is that the times of practice are not satisfactorily fixed from a

* To prevent misunderstanding, it may be well to add that our medical students can at present attend maternity and gynecological practice at the Women's Hospital, children's practice at the Children's Hospital, and eye and ear practice at the Eye and Ear Hospital. It has also been resolved that a course of lunacy practice be arranged at one of the metropolitan Asylums.
practical point of view. It is easy to give illustrations. Thus, by
the University regulations, the second-year students have to
attend out-patient surgical practice, and receive surgical instruc-
tion, yet they know no anatomy. The third-year students are
similarly treated to a course of medical practice, before they know
anything of physiology or medicine, and even at the time when they
were attending lectures in systematic surgery. Again, the fourth-
year students attend surgical practice and clinical lectures on surgery,
and act as surgical dressers, while being lectured to on medicine,
and attend lectures on pathology, at a time when by Hospital
rules, they are prevented from going inside the post-mortem room.
Similarly, the fifth year students devote their final year entirely
to medical practice, though lectured to, and at its close, examined
in surgery as well as medicine. As regards the second grievance,
the matter is at present under discussion, and some improvement
may be expected during the present year. But as regards the
former, no reform seems at present intended. It may be sug-
gested, therefore, that the first year of our medical curriculum be
made a real annus medicus, by placing two at least of its subjects
in the matriculation list, and by introducing in their stead some
elementary anatomy and physiology. Some such alteration
would greatly increase the value of their clinical work, and I will
undertake to bring the matter under the consideration of the
Faculty of Medicine.

It goes also without saying, that we this year anticipate
improvement in the manner in which we ourselves, as a staff, are
to perform our own duties. We hope that this year will witness
an undivided staff, all working for the common end, and that the
increased experience of both clinical lecturers and tutors will
prove of advantage to the School. We hope also to inaugurate
one or more classes in operative surgery, and to introduce a system
by which senior students will act as assistants to the out-patient
staff. And quite a number of prizes either have been, or are to be,
offered as incentives to the students in their work.

But the year on which we are entering will be noteworthy for
other special features. In it, our Hospital is to inaugurate a
properly-equipped nursing school, our surgical wards will be graced
by the attendance of lady students, and our hospital wards are to be
made valuable by the labours of a medical and a surgical registrar.

That the Hospital, by establishing a properly-equipped nursing
school, is about to discharge the third great function proper to
such an institution, must be a source of congratulation to all. It would, of course, be unfair to disparage the work of those who in the past, without systematic training, have qualified themselves within our wards to act as nurses of the sick; and, speaking as an in-patient physician, it is only right for me to say that I have found the nurses generally excellent, and deserving of high praise for their skill and attention. But the system under which they have been trained is bad; far better and greater results might have been achieved; and its re-organisation upon a proper basis must prove a great boon alike to the patients, the staff, and the general public. And the present opportunity may be taken for congratulating the Hospital upon the appointment of a matron both qualified and anxious to undertake this important work.

Of at least equal importance is the determination to appoint medical and surgical registrars. It has long been felt that our Hospital material was not the store-house of statistics and data that it ought to be, that it was only very imperfectly catalogued, and that, for purposes of reference, it was almost useless. It is a matter for congratulation, therefore, that upon the resignation of Dr. Lewellin as Superintendent, after many years of valued service, the Committee accepted the suggestion of the staff, and decided not only to appoint forthwith a Superintendent of standing and experience, but also, at the expiration of office of the present resident medical staff, to elect two registrars (one medical and the other surgical), whose duties will be to supervise and be responsible for the Hospital records in all their branches. This election will take place very shortly, and the gain to the Hospital, to the Clinical School, and to the profession will be very great.

As to the presence amongst us for the first time of lady students, I am not authorised to make any official statement, since the question has not been discussed by the staff. But I should be guilty of a discourtesy, which I should regret, if I did not formally welcome them to the Hospital. Personally, I believe in the right of women to qualify themselves to undertake the work of our profession, and am glad that our University has thrown its medical course open to them. And since our lady students have worked for three years side by side with their fellow students in the class rooms of the University, without difficulty or cavil, and having gained confidence, are now not unwilling to work side by side with them within our wards, I, for one, see no reason to place any obstacle in their path. On the contrary, I would wish
them every success; and from the tact and industry which have hitherto characterised them, I feel sure that they will be found amongst our most deserving and successful students.

And now, after having I am afraid wearied you with this lengthy, but still fragmentary, account of the history and position of our Clinical School, I desire to formally welcome all students to the work which awaits them. To all alike, I would say, make the most of your opportunities, cultivate the habit of observation, of recording what you see, of reading up what can be said about it, and of asking questions upon points which are not understood. You will find it of advantage to be regular and punctual in your attendance, and whole hearted in the performances of your duties. And upon the senior students, further, I would impress the value of careful case-taking, of regular entry of points of interest in the case books, and of aiding the memory and increasing the experience by transferring all the important details of the more interesting cases to a private note book. Upon yourselves depends, mainly, what place you will take in your present class lists and your future profession. And never was the prospect which awaits soundness in work and continuance in study brighter than at present. As the poet sings—

"Life greatens in these latter days,
The century's aloe flowers to-day."

And as regards general conduct, and the attitude which we should all hold towards our work, I cannot do better than quote the wise and eloquent words of Sir James Paget, when, as President of the International Medical Congress of 1881, he gave his famous introductory address before an audience of some 3000 medical men, which included most of the great surgeons and physicians of our time:—

"Let us always remind ourselves of the nobility of our calling. I dare to claim for it that, amongst all the sciences, ours, in the pursuit and use of truth, offers the most complete and constant union of those three qualities which have the greatest charm for pure and active minds—novelty, utility, and charity. These three, which are sometimes in so lamentable a disunion, as in the attractions of novelty, without either utility or charity, are in our researches so combined that, unless by force or wilful wrong, they hardly can be put asunder. And each of them is admirable in its kind. For, in every search for truth, we can not only exercise curiosity, and have the delight—the really elemental happiness—
of watching the unveiling of a mystery, but, on the way to truth, if we look well around us, we shall see that we are passing amongst wonders more than the eye or mind can fully apprehend. And, as one of the perfections of nature is that in all her works, wonder is harmonised with utility. So is it with our science. In every truth attained there is utility either at hand or among the certainties of the future. And this utility is not selfish; it is not in any degree correlative with money-making; it may generally be estimated in the welfare of others better than in our own. Some of us may, indeed, make money, and grow rich; but many of those that minister even to the follies and vices of mankind can make much more than we. In all things costly and vain-glorious, they would far surpass us if we would compete with them. We had better not compete when wealth is the highest evidence of success. We can compete with the world in the nobler ambition of being counted among the learned and the good, who strive to make the future better and happier than the past. And to this we shall attain if we will remind ourselves that, as in every pursuit of knowledge, there is the charm of novelty, and in every attainment of truth, utility, so in every use of it there may be charity. I do not mean only the charity which is in hospitals or in the service of the poor, great as is the privilege of our calling in that we may be its chief ministers; but that wider charity, which is practised in a constant sympathy and gentleness, in patience and self-devotion. And it is surely fair to hold that, as in every search for knowledge, we may strengthen our intellectual power, so in every practical employment of it, we may, if we will, improve our moral nature; we may obey the whole law of Christian love; we may illustrate the highest induction of scientific philanthropy. Let us then resolve to devote ourselves to the whole science, art, and charity of medicine. Let this resolve be to us as a vow of brotherhood. And may God help us in our work.”

Noble thoughts, fitly expressed, and worthy the attention of us all.

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OPHTHALMIC OPERATIONS DURING 1889.

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

I have thought it worth while to briefly place on record the results of operations I have performed during the past year, because my experience during that time has caused me to modify
procedure somewhat, and because Australian statistics of the results of eye operations are wanted, and at present will probably compare unfavourably with European results, in a large measure owing to the prevalence here of chronic ophthalmia. The results recorded are those obtained in both private practice and at the hospital, during the period I was doing Dr. Bowen's work.

**CATARACT EXTRACTION.**

Thirty operations were performed, of which twenty-four were for senile cataract, one for the removal of a dislocated lens, three consisted in the removal of soft lens through a small linear incision, and in two cases (children), the method of discission was adopted.

The method of operation for senile cataract has been as follows:—Preliminary iridectomy, ten to fourteen days before the extraction. Both iridectomy and extraction, usually performed without a general anaesthetic, cocaine being used locally. Before extraction, after the speculum was introduced, the eye was irrigated with warm water, sometimes containing a little boric acid. The section upper, large, and in the sclero-corneal junction. The laceration of the capsule, usually effected by cystotome, in one transverse incision near the upper margin of the lens. After removal of the cataract, the remaining soft lens sometimes removed by irrigating with warm water or boric solution: the eye dressed with a light bandage; the patient kept in bed for a few days; atropine generally used after the third day.

The results of the extraction for senile cataracts have been—

19 good. \( V = \frac{1}{10} \) and more.

2 medium. \( V = \frac{1}{10} \) to \( \frac{1}{10} \).

3 primary failures (closed pupil, owing to iritis).

The best result obtained was \( \frac{9}{10} \) and Jaeger i.

The extraction of the dislocated, and of the soft lenses, all gave good results (\( V = \frac{1}{10} \) and more).

The three primary failures were all due to iritis, which set in and closed the pupil. Later, it may be possible to make an artificial pupil. Vitreous was lost only three times, and in small quantity. Irrigation, for the removal of soft lens, was practised ten times. In two of the cases in which it was practised, iritis set in, but not, I believe, in consequence.

Secondary discission of the capsule was seldom practised; if it had, the vision would probably have been improved in many of the cases. The chief objection has been the unwillingness of the
patient to submit to a further operation involving any risk, when they could see fairly well.

One of the chief advantages of the preliminary iridectomy, appears to me to be the simplified technique of the extraction—absence of blood, saving of time, and diminished necessity for manipulation.

The impression left by the year's work, is that the three points of greatest importance in the operation are—(1) the washing of the conjunctiva beforehand; (2) the making of a large section, and (3) the complete removal of every particle of soft lens it is possible to move.

Of the three cases which developed iritis, one developed it in consequence of hereditary syphilis, and another in consequence partly of insufficient length of section and momentary squeezing during extraction. But in one of the cases which developed such iritis as to close the pupil, the manner of performance of the extraction was apparently not to blame. The whole operation took probably under a minute to perform, the section was sufficiently large, the lens was uniformly hard, and came away without leaving any soft lens behind. In this case the other eye had been operated on previously, and lost in the same way. The explanation of such cases must lie in the presence of arterial, kidney, or some constitutional affection. They will develop iritis no matter how extraction is performed.

Iridectomy.

Seventy-five iridectomies were performed, of which thirty-one were preliminary, eleven optical, and thirty-three antiphlogistic. The latter class included those performed for glaucoma, pannus, ulcers of cornea, &c. No bad result followed the performance of any iridectomy. Pan-ophthalmitis has been unknown to me during 1889.

I have been impressed with the advantage of having an assistant to cut the iris. Iridectomy performed in this way, the operator fixing the eye with one hand, and holding the iris forceps in the other, whilst an assistant cuts the iris, seemed to be performed more uniformly and accurately than by the other method; probably because one man devoting his whole attention, and if necessary, both hands to the cutting of the iris, effects his object better than one devoting a portion of his attention and one hand to the same object.
The following operations were also performed:—Sclerotomy (for glaucoma) one, evisceration one, excision sixteen, pterygium (simple excision) nine, nævus of the lid (electrolysis) nine, on the lacrymal apparatus fourteen, ectropion two, and entropion nineteen.

Latterly, I have employed Van Millingen's operation almost exclusively, completely dividing the lid into two layers, to quite half its vertical dimension; then suturing in a very long and broad strip of the mucous membrane of the lip, in such a manner that the mucous surface is seen through the slit, and in such a manner that it is wholly covered by the layers. Personally, it appears to be the only operation which gives permanent relief in advanced entropion cases.

Fifteen operations were performed for affections of the extraocular muscles. Of these, six were simple tenotomies of the internal or external recti—the former being practised for squint, the latter for muscular insufficiency. One operation consisted in the advancement of the internal rectus, and eight consisted in division of the internal rectus combined with capsular advancement of the external, a proceeding which materially influences the magnitude of the result obtained by division of the internal.

It will be seen, that the figures enumerated do not at first sight justify the statement that chronic ophthalmia prejudices Australian operations somewhat unfavourably, since there was no panophthalmitis. Yet one cannot but feel that an operation, undertaken as so many are on the eye of a patient who has suffered from chronic ophthalmia, and even trachoma, summer after summer, must be comparatively hazardous. I do not feel justified, however, without some direct evidence, in attributing the iritis to this cause. Pan-ophthalmitis would seem to be the only disease which may be specifically assigned to it.

In conclusion, I must express my thanks to Dr. Craig, of the Eye and Ear Hospital, for his kindness in furnishing me with statistics of the operations I performed there.

BROMIDE ERUPTION.

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

The following case, which is interesting as showing the extensive dermatitis which may result from the ingestion of even small doses of a drug to which the patient has exhibited no other signs of intolerance, has recently come under my notice. The clinical notes on the case are somewhat brief. I must, therefore, refer the
reader to the plate which is appended, a glance at which will convey a more accurate impression of the clinical aspect of the lesions, than any detailed description I could give.

Child aged 14 months. He has always been strong and well since birth, with the exception of recent convulsive attacks during teething. There are no signs of past or present constitutional disorder. The eruption, for which the mother brought the child, appeared fourteen days previously. The lesions began as small purplish-red papules, about the size and shape of a split pea. At first, according to the mother’s statement, they appeared as if containing a small quantity of fluid, but when pricked, none escaped. The papules which appeared first on the front of the left leg, have gradually increased in size, both peripherally and vertically, till they assumed their present dimensions; fresh crops continuing to appear daily. None of the lesions have undergone spontaneous rupture.

Present Condition.—On examining the child, there appeared on different parts of the body, but most marked on the legs, deep-red lesions varying in size from a split pea to a Queensland bean. The smaller papules were of a purplish-red colour, raised abruptly from the skin, with an even rounded and glossy surface, looking as if the thin horny layer of the epidermis were tightly stretched over a solid mass of granulation tissue. There is in the majority of smaller papules, a depression or umbilication in the centre, giving somewhat the shape of a vaccinal lesion. The larger lesions present a very striking appearance; the largest of them, those on the anterior and outer aspects of the left leg, as shown in the accompanying illustration, which is in no way exaggerated, since the photo-stipple was taken directly from an ordinary photograph, appear as immense tubercles or tuberose masses, nearly two inches in diameter, and raised a quarter of an inch above the surrounding skin. They rise quite abruptly from the surface, giving one the impression of huge condylomata. In many instances the epidermis covering the lesions, having become sodden, has been rubbed or scatched off (though the subjective signs of itching or irritation seem to be almost nil). The aspect is then somewhat altered, appearing at first sight not unlike the granulation masses in mycosis fungoides. On closer inspection, the raw surface is seen to be uneven, covered with shot-like eminences, with scattered bleeding capillaries, resembling the unhealthy spouting granulation surface of a weak ulcer; minute yellow points about
the size of a pin’s head, which are really miniature pustules, are seen embedded here and there immediately beneath the surface in the larger tuberose masses. On squeezing the tumours, however, no pus is obtainable, but a sainio-serous discharge is observed on the dressings. The general health is excellent. There is no rise of temperature, and the child feeds and sleeps well.

**Distribution of Lesions.**—The left leg (vide illustration) is the most affected; here the tubercles are larger and more numerous than in any other part, there being at least sixteen distinct lesions below the knee, and five or six above it. The right leg is also affected, but to a less degree. The trunk is but little affected, and the face and head are quite free. On the arms and shoulders, the lesions are scattered and small.

**Diagnosis.**

*From Syphilis.*—The smaller lesions might possibly be mistaken for the large papular (lenticular) syphilide, but the absence of any syphilitic history in the parents, and of any concomitant signs in the child, the absence of coppery hue, and later, the disappearance of all the lesions under simple treatment, eliminated syphilis from the question.

*From Impetigo Contagiosa.*—Absence of typical “stuck on” crusts; absence from those parts chiefly affected by impetigo, *i.e.*, face, head, and buttocks; no evidence of inoculation, absence of true vesiculation.

*From Varicella.*—At first, the smaller papules might have been mistaken for those of varicella, but the absence of vesiculation, and of any febrile symptoms, with a tendency on the part of the papules to undergo gradual enlargement into large tuberose masses, would have cleared up the point.

In this case, the clinical aspect of the lesion at once aroused suspicion as to their cause, and on enquiry, the child was found to be taking small doses of *bromide of potash*, which had been continued for three weeks past, in the treatment of mild convulsive attacks during dentition, the dose being *five grains* during the twenty-four hours.

A point of some interest, and of practical importance, lest it should mislead the physician in his diagnosis, is the appearance—as in the case under consideration—of fresh crops of eruption for some time after the discontinuance of the suspected drug. Crocker* supposes that the diuretic action produced by

*Illustrated Medical News, Jan. 12th, 1889.*
administration of sufficient quantities of the salt, stops with the discontinuance of the drug, so that its elimination goes on slowly through the cutaneous vessels for some time afterwards, damaging their walls, producing inflammation and exudation of inflammatory products into the surrounding skin.

**TREATMENT.**

The treatment in the above case was of the simplest character. It consisted merely in discontinuing the drug, and applying a non-irritating antiseptic dressing to such of the lesions as were denuded of epidermis. The whole eruption disappeared within a month.

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**Medical Society of Victoria.**

**Ordinary Monthly Meeting.**

**Wednesday, April 2nd, 1890.**

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

In the absence of the president through illness, and of the two vice-presidents, Dr. LeFevre occupied the chair. There was a fair attendance of members.

Dr. Gresswell, the Medical Inspector of the Board of Health, was introduced to the meeting.

The minutes of the previous meeting were read and confirmed.

Dr. W. McCrea was then elected a honorary member of the Society. Dr. Neild, on behalf of Dr. McCrea, thanked the Society for the honour they had conferred upon him. He referred in eulogistic terms to Dr. McCrea's career, and stated that his name would always be prominent in the medical annals of the colony.

After Dr. W. Moore had shown a case of wound of the forearm, the Chairman called on Dr. Gresswell to address the meeting as to the proposals that he had to make with reference to the prevailing epidemic of Influenza.

Dr. Gresswell thanked the Society for the kindness and cordiality of its welcome. He asked them to regard him now as the representative of the Board of Health. He thought that the Medical Society and the Victorian Branch of the British Medical Association might confer with him, as representing the Board of Health, regarding the present Influenza epidemic. His proposals were:—(1) That a list of questions be circulated. (2) That such questions be framed jointly by the two societies and the Board of Health. (3) That the fact that they have been so framed, be stated. (4) That the answers obtained be the property of the Board of Health,
but that they be available for use by the Medical Societies. As to
the advisability of adopting this course, there were several points
that he would like to refer to. Firstly, this same disease, at least
in his opinion it was so, has been and is being investigated by the
profession and sanitary experts in Europe and America, and an
account of the disease, as seen here, would form a chapter in its
complete history. Here the difference of climates may lead to
features differing from those met with in Europe. Again, in the
opinion of some, the disease is not a new disease, but is identical
with a disease which has been prevalent here in the winter, at any
rate since five years ago, when it was called "fog fever." If this
be correct, it will be regarded by investigators in Europe as a fact
of profound significance, as it will show that they have to deal, not
with an epidemic, separate and distinct, and of recent origin, but
with one which had its origin five years ago. Another point is,
that here we see it in its initial stages, so that we may get a
complete record. He regarded it as certain, that the Board of
Health would be helpless without the aid of the Societies; and
further, the eyes of Europe were upon us, in the hope that we
would furnish some record of the disease as met with here.

Dr. Neild asked Dr. Gresswell if he would mention some
questions such as he proposed to issue. He presumed they would
be on the same lines as those issued by the Epidemiological
Society of England. He was sure that both the Societies would
be glad to co-operate, but if Dr. Gresswell was prepared with a
list of questions, it would help very much in discussing the subject.

Dr. Gresswell stated that the questions he wished to ask,
would be from the Epidemiological side. The Societies would,
no doubt, suggest questions from the clinical aspect. There was
also another side, which he would call the Comparative Patho-
logical (i.e., as to the disease occurring among animals), for in
England it was held by many that there was a disease among
horses which was related to influenza, whilst some medical men
were of opinion that cats were capable of taking it.

Mr. J. P. Ryan moved that the Society cordially thank Dr.
Gresswell, as the representative of the Board of Health, for
bringing the matter forward, and agree to confer and co-operate
with him. This was carried unanimously.

Then Mr. Syme moved that a sub-committee be appointed to
confer with Dr. Gresswell, as to the list of questions to be sent out.
The motion was carried unanimously, and Dr. Neild, Mr.
Girdlestone, and Mr. Syme, were appointed as the sub-committee
The following notes of a case were then read:—

NOTES OF A CASE OF WOUND OF THE FOREARM,
FROM WHICH A PIECE OF UMBRELLA, THREE-AND-A-HALF INCHES LONG, WAS REMOVED.

By W. Moore, M.D., M.S. Melb.
Surgeon to Out-patients, Melbourne Hospital.

J. B., wt. 32, dealer, came as a patient to the casualty room of the Melbourne Hospital on the night of February 15, 1890, suffering from an injury to the left forearm. He stated that he was attacked in the street by a man, who struck him a number of blows over the left forearm with an umbrella. He was suffering considerable pain, and thought that his arm was broken. On examination by the House Surgeon, there was found a small wound on the flexor surface of the wrist, about half an inch deep, and there was an irregularity on the back of the forearm, about the middle. Here a projection could be felt, which was slightly movable. It was thought that there was a comminuted fracture of the forearm, with a loose fragment of bone. He was treated as for fracture.

On Tuesday afternoon, happening to be at the Hospital, I was asked to see the patient, as he had been placed under my care. The arm was then greatly swollen, and, accepting the diagnosis of fracture, I directed the House Surgeon to re-apply the splints carefully. This was done, and a bleb, which existed on the back of the forearm, was opened and a little pus let out.

On the following Saturday, the patient came up among the out-patients. He was looking very ill, and stated that his arm was very painful, that he was hot and thirsty, and unable to sleep. On removing the splints, there was found to be a profuse and foul discharge, both from the original wound in front of the wrist, and also from the opening on the back of the arm. The arm was still greatly swollen; on the anterior surface there was redness extending right up the forearm; on the back of the forearm there was an emphysematous condition, extending from the wound downwards towards the wrist. I therefore made a somewhat free incision into these emphysematous parts, and then, on introducing a finger, felt something which certainly appeared at first to be a loose piece of bone. With a dressing forceps I seized this movable body, and easily extracted, to my great surprise, this piece of the lower end of an umbrella with ferrule attached, measuring three-and-a-half inches. In the wound was a quantity of dirt. The soft tissues of
the back of the forearm, including the muscles, were already sloughing; the radius for about an inch and a half was bare and blackened, but the bones of the forearm were not broken. The wound was now thoroughly washed out with perchloride of mercury solution (1 in 1000), dusted freely with iodoform to keep sweet the extensive sloughs, and dressed with perchloride of mercury ganze. A rectangular splint was kept applied to the front of the forearm and arm, and a cardboard splint was applied to the back of the forearm.

The wound was dressed daily for over three weeks; it was freely syringed through from the first with sublimate solution; the sloughs were picked out as they separated, the last of them coming away about three weeks after the infliction of the injury.

After a few days, a cardboard splint for the forearm was substituted for the wooden anterior splint, and when most of the sloughs had separated, boracic acid powder was used, first with iodoform, then instead of it.

The wound healed well. There was no spreading of inflammation beyond the area first attacked. No drain tube was used. The small amount of damage done to parts in front of the arm was remarkable, whilst the extensor surface suffered very severely, and this was in all probability due to the fact that the ferrule was lodged here, having passed through the interosseous membrane.

The man, as you saw, has good power of extending the wrist, but absolutely no power of extending the fingers. The special extensors of the thumb have also been destroyed, but by means of the adductor, abductor, and flexors of the thumb, he will be able to make some use of it with the index finger.

This case is noteworthy in several respects:—(1) The size of the foreign body measuring three and a half inches, and having the ferrule of the umbrella attached; (2) the fact that the patient not only had no idea that there was anything in his arm, but did not know that he had been poked in the wrist by his assailant; (3) as showing what a dangerous weapon of attack the umbrella is.

You will doubtless all have seen the notice of a case recently, where a fracture of the orbital plate of the frontal bone, resulting in the death of the injured man, was caused in the same way as the accident here described.

It is very easy to account for the foreign body not being detected at the time he first went to the Hospital, as there was nothing whatever in the history given by the patient to lead anyone to
Removal of Fibrous Polypus from Base of Skull.

On the 10th of last month I examined Mr. S., mt. 19, in consultation with Dr. A. S. Aitcheson and Dr. Mailer. The patient informed us, that about two years ago he experienced some

suspect that there was anything in the wound; also his history was exactly that usually given in fractures of the forearm, produced by the infliction of repeated blows. The small opening was not such as you would think likely to give entrance to such a body, and at the time the wound was carefully examined, and traced to a depth of half an inch, but nothing was detected.

Dr. Neild said that Dr. Moore's case reminded him of one that he had seen twenty-two years ago, which was under the care of the late Dr. Thomas. A man, whilst riding in the bush, had been thrown from his horse against the stump of a tree. His face became greatly swollen, and for some time he was under the care of a local practitioner, but as his face continued swollen, and there was some ulceration about the orbit, with what appeared to be a fungus growth which had been treated by various caustics, he sought treatment at the Melbourne Hospital, where he came under the care of the late Dr. Thomas, who upon careful examination, found the growth very hard, suggesting the presence of a foreign body. He thereupon extracted a splinter of red gum, a quarter of an inch thick, and seven inches long. The wound then healed without any trouble.

Dr. Le Fevre commended the character of the paper, stating that the Society wanted ordinary every-day cases of this kind, rather than interesting rarities. He had seen the case of a man, who suffered for several years from a swelling in the upper arm, which had been treated as rheumatism. He thought there must be some foreign body present, so he cut down on it, and found a large size sewing machine needle, which was slightly corroded, but had caused no inflammatory mischief.

Dr. Hamilton thought that the development of emphysema was interesting. He had seen a case where a man, after being injured in the arm by the shaft of a cart, developed emphysema first about the wound, then rapidly extending to the chest and causing death. He was carefully treated by Lister's method.

The following paper was then read:

REMOVAL OF A FIBROUS POLYPUS FROM THE BASE OF THE SKULL.

By T. M. Girdlestone, F.R.C.S. Eng.

Lecturer on Surgery at the University of Melbourne, &c.

On the 10th of last month I examined Mr. S., mt. 19, in consultation with Dr. A. S. Aitcheson and Dr. Mailer. The patient informed us, that about two years ago he experienced some
obstruction in his nostrils, chiefly on the right side; lately both sides have been completely stopped; he has a good deal of difficulty in taking his food, and his sense of hearing is greatly affected. He has suffered repeated attacks of haemorrhage, which are increasing, and are now occurring at short intervals.

At the time of our examination, he was pale and anaemic, both nostrils were occluded at their posterior openings, and the soft palate was considerably depressed by a firm rounded immovable tumour, which occupied a good deal of space at the top of the pharynx, and appeared to be attached to the base of the skull, but the exact point of the attachment could not be made out; the top of the tumour pressed against the skull, and the posterior part of it projected a little beyond the free border of the velum, where it could be seen from the mouth. Excision was advised, and the patient removed into a private hospital for operation.

March 14th.—Chloroform was administered. I first performed tracheotomy, and then plugged the fauces with a sponge, the anaesthetic being afterwards inhaled through the tube in the trachea. Having determined to expose the nasal fosse by Sir Wm. Lawrence's operation, I made an incision round the inferior part of the nose from one side to the other, separating the alæ from the cheek and upper lip; the septum was then divided for about three-fourths of its entire length along the floor of the nares, and the alæ, with the detached part of the septum, were turned up towards the forehead; it was not necessary to divide the nasal process of the superior maxilla. A loop of strong steel wire attached to an écraseur was passed through the nose and round the base of the tumour, which however was tough enough to resist till the shaft of the écraseur collapsed under the pressure of the screw; the wire was therefore removed, a strong chain écraseur used in its place, and the tumour was severed at its point of attachment to the bone, which was found to be at the right side of the body of the sphenoid, immediately behind the posterior nares. The nose was now replaced and retained by sutures, and a piece of dry gauze was applied over the tracheotomy wound.

For the first two days nearly all the nourishment given was per rectum; he afterwards took his food by the mouth, and made a quick recovery. All the face wound healed by the first intention, and left no disfigurement whatever. The small wound in the neck was left to heal by cicatrisation; it certainly might have been closed by sutures, and would then have united by the
Removal of Fibrous Polypus from Base of Skull.

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first intention; however it gave no trouble, and was nearly healed in a week. His temperature rose to 101° on the second evening after the operation, but subsequently it remained at normal. His sense of hearing returned.

On the eighth day he was allowed to return to his home, and on the way, remarked to his brother that the cab made a most unusual noise.

March 28th.—He is gaining strength fast, the soft palate is returning to its natural position, and the appetite is good.

The operation originally performed by Lawrence (Medical Times and Gazette, Vol. II., 1862), was for the removal of several mucous polypi far back in the nares, which defied, as they often will, all the usual means of extraction. It is no doubt most admirably adapted for the above purpose, for it enables the operator to obtain a good view of the growths he desires to remove; it applies equally well for revealing the seat of a fibroid in the pharynx, as in the case here related, and renders the subsequent adjustment of the wire loop, or chain, comparatively easy.

Dr. Barrett said that Mr. Girdlestone was to be congratulated on the successful issue of his case. He had removed many tumours from the same position, but had never seen one as large as that shown by Mr. Girdlestone that he could attempt to remove, as he always found their attachments too extensive. Where the tumours were small, tracheotomy was not required; but in such cases as this, he agreed that tracheotomy was a necessity. Such growths were extremely rare, and such a good result was unusual.

Dr. Kenny said it was rare to meet with a tumour so condensed, more often they were partly mucous, partly fibrous. He did not see the necessity for tracheotomy, and he also thought that the growth might have been removed by passing the galvanocautery wire through the nares, and manipulating with the fingers through the mouth; in this way there would probably be no haemorrhage. In one case, situated not quite as far back as Mr. Girdlestone’s case, he was able to define the origin and attachment of the tumour, which could be seen half an inch below the soft palate; it caused respiratory trouble rather than dysphagia. He was able to pass a platinum wire well into the throat by the nares, and with the fingers in the mouth, get the loop round the growth, so as to remove it. This was done without tracheotomy.

Mr. Syme had recently assisted Mr. FitzGerald in removing a growth like the one under discussion. It was hard and dense, and
under the microscope proved to be a true fibroma. It was attached a little away from the mid-line, very high up, so that it had been previously overlooked; it was not as large as the tumour shown to-night. An attempt was made to pass a wire round it, but it could not be kept on, so the growth was cut away partly with Woakes' curved cutting forceps, and partly with forceps through the nose. A preliminary tracheotomy was performed, and the patient did well. He thought most Continental specialists were averse to large operations, such as Lawrence's.

Dr. W. Moore said that he would like to make a few remarks on the question of performing tracheotomy in these cases. He had seen many operations on the mouth and throat, and when performed without a preliminary tracheotomy, as was usually the case, they were the most horrible sights one could witness. The patient was constantly coming round from the influence of the anaesthetic, and the surgeon had to wait until he was anaesthetized again. This might occur repeatedly, so that the operation would be greatly prolonged, and thus the danger increased. Now a preliminary tracheotomy did not in any way add to the patient's danger, and it made all the difference to the operator between operating in comfort, and in the greatest possible discomfort. Further, in such cases as Mr. Girdlestone's, he could see no reason why the tracheotomy wound should not be sewn up at the time. In one case he had seen this done, where tracheotomy had been performed for excision of the tongue, and the patient had done very well. Recently he had seen several cases in which a preliminary tracheotomy had been performed, and much had always been gained by the proceeding.

Dr. Barrett, with the permission of the meeting, made some further remarks. The only trouble he had seen with chloroform, had been in operations about the pharynx. So great had been the difficulty, that he now has the patient only partially anaesthetized, so that he can cough. The difference between operating in such cases with and without a preliminary tracheotomy, was the difference between comfort and considerable danger. Though in the case under discussion, it might have been possible to remove the tumour with the galvano-cautery, and without tracheotomy, it would have been very difficult, and accidents are so liable to happen—the wire fuses, or slips. The principles of general surgery must be applied to these cases, and we must have plenty of room and light.
Mr. Girdlestone, in reply, said that he quite agreed with Dr. Kenny, that the growth might have been removed through the anterior nares without tracheotomy. But at the same time, tracheotomy was a comfort to the operator, and a god-send to the patient. One danger was haemorrhage; there happened to have been none, but if tracheotomy had not been done and there had been haemorrhage, there would have been great danger. In simple cases, such as this, there was no danger at all in the tracheotomy. He might have sewn up the tracheotomy wound on the completion of the operation, and if he had another such case he would do so. As it was, the patient buttoned his shirt over the wound next day, and there was no discharge whatever from it. He thought tracheotomy essential in such cases. Recently he saw Dr. Moore remove a tongue after doing tracheotomy, and the operation was then a comparatively easy one. As to turning up the nose, he might have got the chain round without, but it would have been very difficult. Such tumours were generally taken away piece-meal, and generally there was great haemorrhage. You can scarcely see a mark, the boy is not a bit the worse, and so there could be no objection to turning up the nose. Lawrence first performed the operation for an ordinary polypus attached very high up, which could not be got at otherwise. A great advantage of this operation is, that if you have not room enough, you can cut through the nasal process of the superior maxilla, and even remove a part of the antrum. Thus you are enabled to see what you are going to do, before you start to do it.

Owing to the lateness of the hour, the remaining business was postponed.

**British Medical Association.**

**VICTORIAN BRANCH.**

**ORDINARY MONTHLY MEETING.**

Wednesday, March 26th, 1890.

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

The President, the Hon. Dr. Le Fevre, M.L.C., in the chair. There was a small attendance of members.

The minutes of the Ordinary Meeting, held on November 27th, 1889, and of the Annual Meeting, held on February 12th, 1890 were read and confirmed.
The President announced that at the last meeting of the Council, the following gentlemen had been elected members of the Branch:—Dr. J. J. Miller, M.B., B.S. Melb., Sydney Road, Brunswick; Dr. J. V. Denning, L. et L. Mid. K.Q.C.P.I., L.R.C.S.I., Macarthur.

It was moved by Dr. J. W. Springthorpe, and seconded by Dr. A. Shields, that a copy of the following resolution be forwarded by the Honorary Secretary to Dr. Gresswell, Medical Inspector to the Board of Public Health:—"The Victorian Branch of the British Medical Association extends a cordial greeting to Dr. Gresswell upon his arrival in Victoria, and whilst congratulating him upon his appointment to the important position of Medical Adviser to the Board of Public Health, would express its hope that in his new and congenial sphere of action, he may be able so to avail himself of his opportunities that his success may be equal to his anticipations, and may win for him a high place in the gratitude of the people of Victoria."

After remarks by Drs. Springthorpe, Shields, Syme, Meyer, Le Fevre, and Neild, the motion was carried unanimously.

The President announced that Dr. H. F. Lawrence had telegraphed, regretting his inability to read his paper, "On the Treatment of Psoriasis," on that evening.

Dr. G. Rothwell Adam's paper lapsed in his absence.

Dr. Felix Meyer exhibited, and gave a short history of, an instance of abnormal foetal development of a rare and interesting type. The specimen was demonstrated by Dr. G. A. Syme, and very great interest was manifested by the members present.

Drs. Neild and Le Fevre expressed the gratitude of the members present to Drs. Meyer and Syme for their trouble in bringing before the meeting such an unusual and noteworthy specimen, and expressed the hope that detailed notes would be published in the Australian Medical Journal.

Drs. Meyer and Syme briefly replied, and promised to further examine the specimen, and present a full report at another meeting.

Death from Chloroform.—A young man died in the Ararat Hospital on the 28th ult., whilst under the influence of chloroform, preparatory to an operation being performed upon him. Every effort was made to resuscitate him by hypodermic injection of ammonia and ether, and artificial respiration was kept up for half an hour, but in vain.
In his address on "Anatomy and Physiology," at the last Intercolonial Medical Congress, Professor Anderson Stuart referred to the great want of good libraries in the colonies, and especially of access to complete sets of scientific serial publications. In Sydney, Prof. Stuart has himself worked hard to supply the want, and by cataloguing the medical periodicals scattered through the various libraries, has enabled inquirers to see at a glance whether any particular journal is in Sydney, and if so, where it may be found. In Melbourne, the energetic Hon. Librarian of the Medical Society, Mr. Webb, has also laboured most zealously in completing sets of periodicals, and building up and cataloguing a reference library. Every member of the profession in Victoria owes Mr. Webb a deep debt of gratitude for the time and labour so ungrudgingly devoted to this work. Still, our medical libraries in Melbourne are not all they might be. The Medical Society Library, the Medical School Library, and the medical department of the Public Library contain much the same books. As regards recent text-books and foreign periodical literature, the Medical School Library is the best supplied, but unfortunately it is the one least accessible to the profession at large.

The authorities at the Public Library are just now showing some activity with regard to its medical section, and if they obtain all the books recommended, it will soon be far the best library of the three. But still it seems a pity that money should be spent in duplicating and tripling books, while so many are at present not to be found in any one of the libraries. Would it not be well for the respective librarians to have a conference, and arrange some plan of concerted action; complete sets, by exchange or purchase; sell some of the triplicated works, and publish a conjoint catalogue, so that inquirers could readily ascertain where a particular work could be found?

With a view of seeing how matters stand in one branch of medical literature, and for his own convenience, Dr. J.
W. Barrett has had compiled a list of the works in the three libraries on diseases of the eye, ear, and throat. We have pleasure in publishing this in the Journal for the information of the profession, and trust that others will volunteer to do the same for other branches. It seems to us that the library ought to be that connected with the Medical Society, just as the medical library in London is that of the Medico-Chirurgical Society. Members now pay a subscription of two guineas per annum, the interest payable on debentures gets less every year, and an effort ought to be made to put the library in a better condition as regards foreign periodicals and recent monographs. At present, the only source of the periodicals now on the shelves is the exchange list of this Journal, but this does not include any but English, American, and Colonial journals.

If in the old days such a library as the Society now possesses could be formed, surely it is not too much to expect the present members to keep it up to the same standard, and the privileges of using a first-class library ought to be an inducement for new members. Without a complete, accessible, and well-catalogued library, original research is almost impossible nowadays; and as Prof. Stuart remarked, such an institution is a greater necessity in new countries where investigators are isolated from one another, than in older countries where so much is learned from conversation, and the personal friction of mind with mind. The profession in Adelaide have taken the matter up in earnest, and organised a subscription library. Now that attention has been drawn to the subject here, it is to be hoped that a determined effort will be made to keep up the reputation of Melbourne in this respect.

News has been received by cable that an Order in Council had been passed making the Imperial Medical Act apply to Victoria. This is the first step towards having medical degrees which have been conferred by the Melbourne University recognised in Great Britain. It will now be for the Melbourne University authorities to apply to the General Medical Council of Great Britain to have the medical degrees conferred by that institution recognised in the old country. When they are so recognised, medical students who have passed through the Melbourne University, and obtained their degrees, will, on proceeding to England, be registered as practitioners in Great Britain, and will be permitted to practice there as such without undergoing any further examinations.

Dr. Murrell has added to the list of booklets with which his name is already associated this record of a series of therapeutical attacks on that opprobrium medicinae, chronic bronchitis. He recounts in seven successive chapters the results which he has obtained by treating it with ipecacuanha and other sprays, tar and its allies, pure terebene and its allies, cheken and cubebs, chloride of ammonium inhalations, and fuming inhalations; and he has experimented with these various remedies, not only on chronic bronchitis, but also on coryza, phthisis, and spasmodic dyspnœa, and the general impression left from a perusal of the book is, that all of these modes of treatment have their uses, and nearly all are superior to the routine and interminable repetition of ammonia, squill, opium, and senega, to which the physician too often resigns himself and his patient. Some of Dr. Murrell's results are almost startling to those who are accustomed to the ordinary intractable behaviour of chronic bronchitis, especially as it is seen in the out-patient departments of hospitals. To all such, or at least to those among them who have not yet sunk into utter despair of attaining anything beyond palliative treatment of recurrent winter cough, this "clinical study" may be commended, as at least a suggestive and interesting record of the author's personal experience, and of his perhaps too sanguine faith in the efficacy of medicaments in inveterate diseases.

Dr. Murrell, as a pharmacologist, is necessarily sanguine as to the effects of drugs, and possibly his reports are more rose-coloured than might have been those of an observer more alive to the stern facts of pathological change.

The book is written in the author's well known agreeable style, and is not burdened with the pedantry of too precise observations. The records of cases are characterised by an airy lightness, which relieves the gloom of the subject, and which it would perhaps be hypercritical to describe as flippancy. We are told, for instance, of "G. H., a Member of Parliament," who says "the smell of the sandal-wood is strangely familiar to him—can't account for it;" and of "Thomas S., æt. 42, cook in the House of Commons,"
who attributes his cough, "partly to the heat of the kitchen, and partly to having to cater for members of such various shades of political opinion. . . . . He drinks beer, the wines of the House not being quite up to his mark." Apart from this slight blemish of frivolity, the substance of the book may be regarded as a really useful contribution to the better treatment of a malady, which causes incalculable distress.

D. G.

Hospital Intelligence.

ALFRED HOSPITAL.

At its meeting on the 14th ult., the Committee granted Dr. F. W. Elsner sick leave for a few weeks.

On the recommendation of a committee, consisting of members of the Managing Committee and the Hon. Medical Staff, it was resolved to appoint another hon. physician for in-patients. A similar recommendation for an extra physician for out-patients was held in abeyance for the present.

On the 21st ult., Dr. J. H. Saunders was elected to the position of temporary resident physician for a period of three months, during the typhoid season.

There were seven applications (one informal) for the position of honorary physician for in-door patients. On the 28th ult., a ballot was taken, and Dr. Charles L. Lempriere was declared elected.

THE WOMEN'S HOSPITAL.

At the meeting of Committee held on the 20th ult., a motion was moved by Mrs. Moloney:—"That no person shall be eligible for election as a resident medical officer, unless in addition to the requirements of the Medical Practitioners' Statute of 1865, he be possessed of a degree in medicine and surgery from the University of Melbourne." Mrs. Moloney stated that, at a late election, a licentiate of another University was accepted in preference to a local M.D., and she thought that a locally trained officer, if his qualifications were satisfactory, should have the preference. Mr. Templeton seconded the motion, which was lost by ten votes to five.
The General Committee of the Geelong Infirmary and Benevolent Asylum, at a meeting held on the 2nd inst., elected Dr. Kennedy of the Melbourne Hospital, as resident surgeon, in place of Dr. Marwood, who recently resigned. There were nineteen applications.

**Vital Statistics.**

The Government Statist's report on the vital statistics of Melbourne and suburbs for February 1890, shows that the births of 1401 children—718 boys and 683 girls—were registered. The deaths registered numbered 878, viz., 472 of males and 406 of females. The births thus exceeded the deaths by 523, or 60 per cent. To every 1000 of the population of the district, the proportion of births registered was 3.06, and of deaths registered 1.91. One hundred and forty-five deaths, or 17 per cent. of the whole, took place in public institutions. The number of children under one year who died was 295, the total number under five years being 425. Specific febrile or zymotic diseases, which caused 198 deaths in the thirty-one days of January, caused as many as 210 deaths in the twenty-eight days of February. Under this head, deaths from diphtheria increased from 25 to 46, deaths from scarlet fever from 6 to 7, and deaths from whooping-cough from 6 to 8. On the other hand, deaths from typhoid fever fell from 78 to 73, and deaths from diarrhoeal diseases from 74 to 66. In addition to the deaths from diphtheria, 2 deaths were set down to diphtheritic croup in both months. In January 17, and in February 10 deaths were set down to sunstroke, as against only 4 deaths from that cause in the former, and no deaths from that cause in the latter month of the previous year.

The following is a statement of the deaths set down to typhoid fever and diphtheria in each month of 1890, and the two previous years:

<table>
<thead>
<tr>
<th>MONTHS</th>
<th>Typhoid Fever</th>
<th>Diphtheria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1888</td>
<td>1889</td>
</tr>
<tr>
<td>January</td>
<td>9</td>
<td>70</td>
</tr>
<tr>
<td>February</td>
<td>63</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>134</td>
</tr>
</tbody>
</table>
Correspondence.

IODISM FROM A SINGLE INTRA–UTERINE APPLICATION.

To the Editors of the Australian Medical Journal.

Sirs,—In the above paper of Dr. Adam's, where iodine gr. 75, pot. iodid. gr. 90, were injected, he says, "I think it is unique to have iodism after a single application of even a strong preparation of iodine to the endometrium."

In 1883, I swabbed the interior of the uterus of a lady who had lain for six months in a specialist's hospital, suffering from metritis, with enlarged uterus, with little or no benefit. Iodism followed within twenty-four hours, and again a fortnight later, and pregnancy soon after. In 1889, I swabbed two—both however for diseased endometrium, connected with retained decidua of some duration, containing much granulation tissue—with iodised phenol. Iodism followed in each case. In neither would absorption be favourable.

Iodised phenol (Goodell), contains $\frac{1}{3}$ iodine, camphor, carbolic acid, and chloral. I never got all the iodine to dissolve, and never used more than $\frac{1}{3}$ iodine at a sitting. There is no pot. iodide to keep the iodine in solution after injection.

Gynaecologist's dictum, that the endometrium does not absorb, has appeared to me to be more an idea than a fact, the absorption of products following labour being in point.

Absence from town has prevented an earlier notice on this subject.

Collingwood, April 8, 1890.

JOHN REID, M.D.

MUSCÆ VOLITANTES.

To the Editors of the Australian Medical Journal.

Sirs,—In connection with Dr. Barrett's interesting paper on the above subject, will you kindly ask Dr. Barrett to comment on the following points:—(1) Fixed opacities in the eye media cease soon to have any significance to the subject (leucomata, &c.)—Cf., the blind spot. (2) Vitreous opacities to the observer would be much more highly magnified than to the patient—to the latter, they would be diminished in size. (3) In smoker's amblyopia
there is frequently a complete blank; after images are, I believe, common. (4) Fluctuating entities peculiar to the subject are, (a) Disturbances in the vascular system within the eye—it is of course well known that the B.V. of one’s own eye can be observed by oneself—vascular refers to lymphatic system as well; and (b) Foreign bodies on the cornea—these include the distribution of liquids for the time being, and also particles of dust, whose size would be magnified. Often muscve in strong sunshine have the appearance of large beads, &c.

Trusting that the above will lead to further explanation and examination of the subject.

Collingwood,
April 8, 1890.

Yours, &c.

JOHN REID, M.D.


Health Officers.—The following appointments have been confirmed:—Borough of Tarnagulla—Richard John Leeper, L.R.C.S. Irel., vice Dr. Macdonald leaving the district; Shire of Seymour, Avenel Riding—Robert Smith, L.R.C.S. Edin.; Shire of Numurkah, Western Riding—John Ellison, M.D., vice Dr. John McGuinness resigned; Shire of Oakleigh—Reginald Herbert Morrison, M.B., vice Dr. D. Simpson resigned; Shire of Yarrawonga—Katamatite and district.—George Richmond Moore, M.R.C.S. Eng.

Public Vaccinators.—The following appointments have been made:—Tarnagulla—Richard John Leeper, vice G. B. D. Macdonald, M.B., whose resignation has been accepted; Lorne and Dean’s Marsh—Lionel Selfe Wells, L.R.C.P.

Medical Practitioners to Examine Patients Boarded Out from Lunatic Asylums.—The following appointments have been made:—Louis Gordon Leslie, L.R.C.S. Edin., Butherglen; Archibald Macdonald, M.D., Sale: James Forrester Matthews, M.R.C.S. Eng., Branxholme; William Francis Sweetnam, M.D., Mortlake; David Trumpy, M.D., Warragul.
ROYAL COMMISSION ON CHARITABLE INSTITUTIONS.—The following gentlemen have been appointed Members of a Royal Commission, to inquire into and report upon the condition and management of the Charitable Institutions of the Colony:—Ephraim Lamen Zox, M.P. (Chairman); The Honorable James Campbell; R. Murray Smith, C.M.G.; R. L. J. Ellery, C.M.G.; Edward Ellis Morris, M.A.; Thomas Harlin, M.A.; James Boyd, M.D.; Andrew Anderson, E. Ashley, George Baker, F. R. Godfrey, and consider the following questions:—

1. The allocation of the amount annually voted by Parliament as a grant to Charitable Institutions.

2. The advisability of requiring municipal bodies to contribute towards the erection of Charitable Institutions, and towards their maintenance.

3. The mode of collecting funds by private contributions or otherwise on behalf of Charitable Institutions, and the system which should govern the distribution of receipts between the maintenance fund and the formation or increase of endowment funds.

4. The relief of the immediate and pressing wants of the poor of the community.

5. The limitation of the benefits of Charitable Institutions to those who from poverty or other causes, are entitled to participate in them, and the advisability of establishing pay wards, and the conditions of admission to such wards.

6. The more general introduction of female nursing in hospitals, the training of nurses, and the general improvement of the system under which such nurses are employed.

7. The transfer from Hospitals to other Charitable Institutions of indigent or helpless persons who are no longer in need of hospital treatment.

8. The method of disposing of children in Orphan Asylums subsidised by the State.

9. The manner of making persons contribute towards the support of indigent relations, who are burthens upon Charitable Institutions, and the best means of recovering moneys due to such Institutions.

10. And generally into all matters connected with the premises.

Dr. Gresswell, the medical expert who has been appointed by the Government on the staff of the Public Health Department, entered upon his duties on the 24th ult. During the next few months, he will devote a good deal of time to making a sanitary survey of the colony. He intends visiting all the centres of population, and the country districts for the purpose. He will pay particular attention to the ventilation and drainage of dwellings, lodging-houses, and hospitals, the methods of removal and disposal of household refuse, the systems of street drainage, the condition of dairies, slaughter-houses, and piggeries, the water supply of towns, the administration of the sanitary laws, and other matters pertaining to the public health. Wherever Dr. Gresswell sees necessity for sanitary works to be carried out, such as the drainage of a street, the discontinuance and covering up of a corporation tip, or the better ventilation of public institutions, he will at once report the matter to the local authorities, so that they can consider the necessity of making the required improvements.
THE MEDICAL STUDENTS’ SOCIETY.—The tenth annual general meeting of the Medical Students’ Society was held at the Melbourne Hospital on the 18th ult. There were about 60 members present, and the chair was occupied by Dr. Springthorpe. The report stated that eight general meetings had been held during the year, at one of which a public lecture was delivered by Dr. J. P. Ryan, on “Surgical Reminiscences of the Franco-Prussian War,” and the success which attended this lecture would probably lead to the extension of the system during the present year. Efforts had been made to induce the Committee of the Melbourne Hospital to adhere strictly to the rules of that institution, in making appointments on their resident staff from the honour lists of the University; and the committee of the Alfred Hospital had also been requested to confine their appointments to the same positions to Melbourne graduates. Reference was also made to the prosperous condition of The Speculum, the journal of the society, and to its value as a means of advancing the interests of the Medical School and of the students generally. It was announced that an anonymous friend of the society had offered a prize of 10 guineas for the best original article contributed to that journal during the ensuing year. The treasurer’s report showed a total income of the Society of £350, and a credit balance of £97.

BIRTHS.

BAGE.—On the 23rd ult., at Achernar, Toorak-road, South Yarra, the wife of Dr. Charles Bage, of a daughter.

CLENDINNEN.—On the 1st inst., at Haven, Malvern-road, Hawthorn, the wife of F. J. Clendinnen, M.D., of a daughter.

JACK.—On the 1st ult., at Ardstran Villa, Stawell, the wife of R. Nelson Jack, L.R.C.P., L.R.C.S.E., J.P., of a daughter.

NICKOLL.—At her residence, Weeroona, Mudgee, N.S.W., the wife of Dr. Harvey Nickoll, of a son.

SCHLESINGER.—On the 9th ult., at Elleradie, Wellington-street, Windsor, the wife of Dr. R. E. Schlesinger, of a son.

MARRIAGES.


PALMER—BENBOW.—On the 13th Feb., at Ararat, by the Rev. R. Meade, George Palmer, resident surgeon, Ararat Hospital, second son of H. S. Palmer, Esq., to Caroline Jane, relict of the late T. W. Rodway Benbow, Esq.


DEATHS.

BARR.—On the 2nd inst., at Burwood-road, Hawthorn, Thomas James Barr, M.D., physician-surgeon, aged 44.

KNAGGS.—On the 23rd ult., at his late residence, 134 Dudley-street, West Melbourne, Robert N. Knaggs, M.R.C.S.E., in his 91st year.

MASEY.—On the 15th ult., at Daylesford, Eyre Henry Charles Masey, M.D., L. et L.M., R.C.P.S., Edin., younger son of the late John Masey, of Stagdale, County Limerick, aged 42.

# Appendix.

**Catalogue of Books and Periodicals on the Physiology and Pathology of the Eye, Ear, and Throat Contained in the Melbourne Libraries.**

Compiled for J. W. Barrett, Assistant Surgeon to the Victorian Eye and Ear Hospital, by C. Price, Assistant in the Physiological Laboratory of the Melbourne University.

The works are entered in chronological order. The abbreviations used are as follows:—Melbourne Public Library, M. P. L.; Medical Society Library, M. S. L.; Medical School Library, M. Sch. L.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Book</th>
<th>Author</th>
<th>Publishers</th>
<th>Library Placed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1800</td>
<td>A Treatise on Ophthalmic</td>
<td>Edward M. Noble</td>
<td>G. G. and J. Robinson, Lond.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1809</td>
<td>Fungus Hæmotoxes of the Eye</td>
<td>J. Wardrop</td>
<td>George Ramsay, Edin.</td>
<td>M. S. L.</td>
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<tr>
<td>1819</td>
<td>Morbid Anatomy of the Eye</td>
<td>James Wardrop</td>
<td>Arch. Constable, Edin.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1826</td>
<td>Operations performed on the Eyes</td>
<td>W. Cleobury</td>
<td>T. and George Underwood, Lond.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1827</td>
<td>Operative Surgery of the Eye</td>
<td>G. G. Guthrie</td>
<td>Burgess and Hill, Lond.</td>
<td>M. S. L.</td>
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<tr>
<td>1830</td>
<td>Diseases of the Human Eye</td>
<td>A. Watson</td>
<td>MacLachlan and Stewart, Edin.</td>
<td>M. S. L.</td>
</tr>
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<td>Date Pub'd.</td>
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<td>Publishers</td>
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<tr>
<td>1836</td>
<td>Laryngismus Stridulus—Croup</td>
<td>Hugh Ley</td>
<td>John Churchill, Lond.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1837</td>
<td>Surgical Pathology of the Tonsil and Trachea</td>
<td>W. H. Porter</td>
<td>Sherwood, Gilbert and Piper, Lond.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1838</td>
<td>Structure and Diseases of the Ear</td>
<td>George Pilcher</td>
<td>Sam. Highley, Lond.</td>
<td>M. S. L.</td>
</tr>
<tr>
<td>1840</td>
<td>On Deafness</td>
<td>J. Yearsley</td>
<td>John Churchill, Lond.</td>
<td>M. S. L.</td>
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<tr>
<td>1840</td>
<td>Strabismus</td>
<td>Bennett Lucas</td>
<td>Sam. Highley, Lond.</td>
<td>M. S. L.</td>
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<tr>
<td>1841</td>
<td>Diseases of the Eye</td>
<td>W. Mackenzie</td>
<td>Longman, Green, Orme &amp; Co., Lond.</td>
<td>M. S. L.</td>
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<tr>
<td>1841</td>
<td>Diseases of the Eye</td>
<td>W. Lawrence</td>
<td>Whittaker and Co., Lond.</td>
<td>M. S. L.</td>
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<td>1841</td>
<td>Physiology of Vision</td>
<td>W. Mackenzie</td>
<td>Longman, Green, Orme &amp; Co., Lond.</td>
<td>M. S. L.</td>
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<td>1841</td>
<td>Cure of Squinting</td>
<td>F. W. Grant Calder</td>
<td>Henry Renshaw, Lond.</td>
<td>M. S. L.</td>
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<td>1844</td>
<td>On Deafness and Diseases of the Ear</td>
<td>W. Dufton</td>
<td>H. Renshaw, Lond.</td>
<td>M. S. L.</td>
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<td>1844</td>
<td>Contributions to Aural Surgery</td>
<td>W. R. Wilde</td>
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Books on Eye, Ear, and Throat.
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1899 Books on Eye, Ear and Throat.
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