SOME REMARKS ON DIPHTHERIA, WITH CASES.

By JOHN BLAIR, L.R.C.S.

[The substance of the following paper was read at the meeting of the Medical Society, on June 10, and the various preparations of exuded membrane exhibited.]

The disease known as Diphtheria has, during the last few months, assumed such an increasingly serious character as to cause anxiety to the medical attendant and alarm to the general public. Its ravages have not been confined to any particular section of the community, nor to any particular age nor social station. All ages and conditions have alike suffered, and the insidious nature of its approach has rendered it all the more formidable.

Diphtheria made its first appearance in Melbourne and suburbs in 1858, and I am indebted to the statistics of the Registrar-General for the following information as to its progress. During that year, six deaths were registered as occurring from Diphtheria, and the mortality to the end of June, 1868, is as under:

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The greater number of these deaths occurred in the suburbs—Emerald-hill, Sandridge, St. Kilda, Brighton, Brunswick, Hawthorn, Kew, South Yarra, Prahran, Richmond, Northcote, Collingwood, and Footscray. Not only is the death rate doubled for the past six months, but the disease has assumed a much more virulent character, and this may be attributed, I think, to the unusual prevalence of cold north winds. Certain it is, however, that the epidemic has been of a more malignant type than we have been visited with hitherto. In a paper contributed to the Medical Journal on Diphtheria, in July, 1861, by Dr. Mackenna, he states:
"By what we can gather from books, the diphtheria of this colony is very much milder than that which has appeared in England, and it is very probable that if the same observer had witnessed a sufficient number in both countries to enable him to form a just opinion, he would discover differences quite as great as are those of climate and latitude. The deaths, in adults were extremely few, being confined to children of tender age."

In another paper, in the *Journal* of July, 1865, by Dr. Richardson, of Ballarat, I read: "There are certain diseases whose names are, from associated ideas, more dreadful to the public mind than the reality, more fatal in imagination than in truth;" thus conveying the belief that he regarded the disease as the reverse of formidable. Out of 270 cases of diphtheria occurring at Ballarat, Dr. Richardson had only eighteen fatal cases, which amply accounts for his estimating the epidemic so lightly. In another part of his paper he says: "It may be with reason stated, that with our present knowledge of the disease, death ought not to occur from this cause in adults, and that in unless rare and complicated cases, children are not, or at least ought not to be, the victims commonly supposed." These remarks suggest a very different state of matters from the disease we have had to battle with during the past six months.

In many cases which have come under my notice, the patient has complained of a slight pain in the throat, and in twenty-four hours from the first symptoms of the attack a false membrane has been exuded on the fauces, extending not only into the larynx and trachea but the oesophagus, with the alarming symptoms of dysphagia and impending asphyxia supervening.

Dr. Gibb remarks in his work on *Diseases of the Throat*: "Its ravages have been such that whole families have been cut off by it. Child after child has been snatched away, and the most persevering efforts of our art have failed in arresting its progress. Fortunately, the complaint and its consequences are now so much better understood, that practitioners are more on the alert for the earliest symptoms, and, as a consequence, treatment has been more successful."

At a recent meeting of the Medical Society I had the honour of laying before the members the history of a case of malignant diphtheria, when I exhibited the exuded membrane expelled by the action of the xylo-styptic ether, and it is my present intention to follow up that case, and to lay the results, favourable as well as unfavourable, before the profession for the better elucidation of the nature and treatment of this alarming scourge. Before, however, I do so, it might be as well to take a retrospective view of the history of this disease.

Diphtheria has been known to exist over different parts of the continent of Europe for upwards of 300 years; but the first notice we have of it in England is contained in Dr. Fothergill's Account of the Sore Throat, published in 1748: "If the mouth and throat be examined," says Dr. Fothergill, "soon after the first attack, the uvula and tonsils appear swelled; and these parts, together with the
velum pendulum palati, the cheeks on each side near the entrance into the fauces, and the pharynx appear of a florid red colour. Instead of this redness, a broad spot or patch of an irregular figure, and of a pale white colour, is sometimes to be seen. All parts of the fauces were liable to be affected; but the disease in general first appeared in the angles above the tonsils, or on the tonsils themselves, on one of the arches formed by the uvula and tonsils, on the posterior wall of the pharynx, or on the base of the tongue.

An epidemic of this nature occurred at Chesham, in Buckinghamshire, in the year 1794.* It was not confined to the town, which lies in a valley, but appeared likewise with equal violence upon the neighbouring hills, at a distance of five or six miles. The subjects were children from the first to the fourteenth year of their age, and it attacked many fine, healthy, robust children, as well as the pale, phlegmatic, and delicate. The illness crept on imperceptibly at first, the patient appearing to be in good health, the countenance not altered, and, excepting at intervals, the appetite and spirits unimpaired; but it sometimes happened that symptoms which had appeared trifling for two or three days suddenly increased, and the disease then advanced so rapidly as to prove fatal before many hours had elapsed.

Bretonneau was the first author who described it as Diphtherite, in 1821, and according to him the exudation is the special character. In one case the larynx and trachea were lined with a thick false membrane, which formed a complete tube, and extended to the third ramification of the bronchial tubes.

In 1825 Dr. Mackenzie, of Glasgow, published a short paper in the *Edinburgh Medical and Surgical Journal*, vol. xxiii., where he says, "the exudation very frequently commences on the surface of the tonsils, thence spreads along the arches of the palate, coats the posterior surface of the velum palati, sometimes surrounds and encloses the uvula; and at last descending, covers the internal surface of the pharynx and oesophagus, the larynx, and trachea." And in a case that proved fatal, on examination after death, he states, "I was surprised, on dissection, to find the tonsils and uvula entire, and coated over only with an effusion; for I had laid my account to find a loss of substance in those parts." He then announced to his medical brethren that what had been considered as ulcers, were nothing else than effused lymph, the progress of which over the velum and uvula, and towards the alimentary and respiratory passages, he had distinctly observed.†

Dr. Edward Headlam Greenhow, of St. Thomas' Hospital, narrates the first case that came under his notice, as that of a medical friend in London, who consulted him early in October, 1857, for a sore mouth, attended by a firm, thin, filmy, but opaque white exudation, chiefly upon the gums and buccal mucous membrane, but

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* Transactions of a Society for the Improvement of Medical and Chirurgical Knowledge, vol. ii.
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The late Professor Alison, of Edinburgh, treated a case of diphtheria in the wards of the Royal Infirmary, which formed the subject of a clinical lecture in 1830; there was inflammation of the left tonsil, soft palate, and uvula, and effusion of coagulable lymph. For some days the difficulty of deglutition was slight, nor was the breathing much affected; but the inflammation spread down the air passages, and continuing to do so, notwithstanding the measures adopted for the patient's relief, proved fatal within thirty-six hours.*

Dr. Abercrombie relates a case of sporadic diphtheria: "A gentleman, aged twenty-six, came to town to consult him about a complaint in his head. On his journey he thought he caught cold in crossing the Firth of Forth, and he complained of glandular swelling on the right side of his neck. His voice was hoarse, with a peculiar husky sound, the fauces were red, yet without much swelling, but were covered in several places with aphthous crusts. He had some dyspncea, with considerable difficulty of swallowing. The attempts to swallow excited sometimes cough and sometimes vomiting, and by both he brought up considerable quantities of a soft membranous substance. He became more and more exhausted, without any remarkable change in the symptoms, and died at the end of about three weeks from the first appearance of the disease. For twelve hours or more before his death he swallowed pretty freely."

Mr. Birch examined two cases after death. The false membrane in the pharynx was found to extend through the glottis, down the windpipe, and throughout the larger bronchial tubes.†

Dr. Greenhow, in his treatise on Diphtheria, narrates a case of occasional limitation of diphtheria to particular dwellings, as if the houses themselves were the source of infection: "A family at Spalding, every member of the household—parents, children, governess, and servants—suffered from diphtheria in November, 1858. Another female servant, subsequently engaged, was attacked by the disease in the same house in March, 1859. An entire family was swept away by the epidemic at Snowden, in Hampshire. The house was well conditioned, pleasantly situated, and there was nothing either in the house itself or its immediate neighbourhood which could be supposed to account for the calamity which befell its inmates, all of whom perished, but at different periods."

Dr. Gall relates a case of a similar kind which came under his notice. In three different houses, after a child had died of diphtheria, the rest of the family were sent from home, and remained absent until all danger from infection was supposed to have ceased. In each instance they remained well during their absence, but, on their return home, the disease reappeared, and fatally.‡

* Lancet, 1829, vol. i.
† Medical Times and Gazette, August, 1859.
There can be no doubt of the close resemblance of the epidemic with which we are now visited, and the cases I have just cited.

The first case to which I refer is that of the young lady which I read before the Medical Society in May last, when the successful employment of the xylo-styptic ether caused the expulsion of the fibro-albuminous membrane, and so gave instant relief. My hopes, however, were doomed to disappointment, for in a few days the membrane was again exuded, and by the same agent large casts were expelled. I kept the patient up with strong beef-tea, applied poultices round the throat, administered Tinct. Ferri Sesquichlor. in ten minim doses every three hours. I gave at intervals Potass. Chlorat. with honey and Hydrochloric Acid and small doses of brandy every hour. She continued in a low state with a pallid anaemic aspect for two days, and ultimately sank from exhaustion, the blood poison being too much for her. But I am convinced that if the xylo-styptic ether had been applied earlier, and the membrane thrown off before so much constitutional mischief had set in, she would have had a fair chance of recovery, for I believe the disease to be first local and then constitutional. I had an opportunity of making a rather hurried post-mortem examination in this case. I was anxious to see the condition of the parts after the exudation of the large membrane I exhibited at the meeting of the Society. It was a complete mould of the larynx, trachea, and division of the bronchi, and on the renewal of the exudation, a second membrane, which I preserved, equal in length although not so complete nor so firm in texture, was expelled. The mucous membrane from which the exudation had been exfoliated was much congested and swollen, and some small patches about the size of a split pea ulcerated, and numerous small thready adhesions and very minute bloody points were just perceptible. The tonsils were swollen and infiltrated with blood. The oesophagus and the tissues round the fauces were very much congested. The lungs were emphysematous, particularly the right lobe, and a small patch of false membrane was adherent at the bifurcation of the trachea. It was so tough as to require considerable force to tear it; it closely resembled a bit of moist chamois leather. I had not an opportunity of examining the other organs.

Case 2.—R. N., a waiter at the Café, aged 26, consulted me in May last. He complained of anomalous symptoms about the throat and neck with dysphagia. On examining the throat, a patch of diphtheritic membrane was distinctly visible. The local application of the styptic caused its expulsion, and he expressed himself relieved. He used a mixture of Chlorate of Potash and Tinct. Cinchon. (to save space and time I need not give the formula.) In a few days he was convalescent and resumed his duties. I believe his rapid return to health was owing chiefly to the removal of the local cause of the disturbance.

Case 3.—Mr. E., æt. 40, living in John-street, Fitzroy, complained of difficulty in swallowing, and a feeling as if there were a body at the back of the throat, with much uneasiness and irritable cough. On examining his throat, I found his uvula very much
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elongated, and considering this the cause of all the mischief, I removed it with a pair of curved scissors to the extent of two-thirds; the relief was immediate. Two days afterwards he became affected with diphtheria. On the application of the ether, the membrane was displaced. He used a mixture of honey, Hydrochloric Acid and Cinchona, and was convalescent in a few days.

CASE 4.—A healthy looking child, aged one year and a half, living in Drummond-street, Carlton, in April last, became peevish and fretful; had been subject to severe fits of coughing some days previous to my visit. His face was flushed, his pulse throbbing, and there was extreme dyspnœa. On examining the throat, the exudation on one tonsil was plain enough, and I treated it for diphtheria in my ordinary way; pieces of diphtheritic membrane were expelled. In about three weeks the child made a good recovery, and I discontinued my visits. This child after being a week convalescent had a sudden relapse, and during my absence in the country another medical man was called in, who continued to attend until my return. He considered the case to be well defined diphtheria. The child again commenced to improve, and the servant maid became ill. There was great enlargement of the tonsils, and difficulty of swallowing: the communicability of the disease in this case was clearly demonstrated. On the following morning the fauces and tonsils were coated with membrane, accompanied with great depression. I used again the local application, the ether styptic being freely brushed over, and the membrane peeled off. By administering Bark and Ammonia internally, and Sesquichloride of Iron and honey—a tea-spoonful occasionally—she made a good recovery.

CASE 5.—The communicability of the disease was still more marked in this case. Two single ladies came on a visit to the house of the last described patient. One of them became affected seriously, and it was with the greatest difficulty she could swallow. She was treated in the same manner as the previous case, and made a very slow recovery.

CASE 6.—Mrs R., aged sixty-one, also paid a visit to the house in Drummond-street, principally to see her grand-child—the convalescent baby. She remained in the house a day or two, and then complained slightly of a disagreeable pain in her throat; but she did not think it necessary to obtain medical advice, under the impression, as she expressed herself, that she had got a bad cold, and it would wear off. She accordingly returned home to Brunswick, and it was two or three days from the time the first symptoms made their appearance before I was summoned. When I examined the throat it presented exactly the appearance of the first case narrated in this paper. Patches and a whole cast of the trachea and bronchi were expelled by the use of the styptic, only to be again exuded. Carbolic acid applied copiously did not prevent the formation of the membrane, although applied immediately after its expulsion. Of all the preparations to stimulate and assist in the expectoration of mucus and of membrane, Senega seemed to me to be the most
efficacious. This lady died on the fifth day. The quantity of membrane expelled exceeded anything I ever saw or read of.

Case 7.—J. R., aged twenty-four, the son of the deceased, a strong young man, just returned from sea, after a few days residence in the house became affected in a similar manner to his deceased mother. An immense tough thick membrane was expelled on using the styptic ether several times. For a week he had a great struggle for life, and he is now convalescent.

Case 8.—The sister of J. R., aged eighteen, after a few weeks residence in St. Kilda, returned to Brunswick. She had quite recovered from a former attack, but after a few days residence in the infected house, she was again prostrated, and had a severe struggle for existence. The symptoms and treatment were the same as the preceding case. In this case also the membranes were expelled.

I think that I have now said sufficient to convince the most sceptical of the infectious and contagious nature of the disease. Sporadic cases have been under my care in Kew, Upper Hawthorn, Richmond, and Heidelberg. It frequently happens that patients continue to move about without complaining much until the disease has reached an almost hopeless stage. The difference between real diphtheria and the cases of mild sore-throat which frequently co-exist appears to consist only in degree. The essential character of both is the inflamed throat and fauces; the milder may differ from the worst forms of diphtheria, yet the two forms appear to me gradually to run into each other, so as to make it a matter of difficulty to draw the line of demarcation. Hence cases appear of every intermediate shade of severity in the same epidemic.

I am inclined therefore to consider diphtheria first as a local disease, and that this sets up the constitutional or blood disorders—a complication in its worst form of asphyxia, dysphagia, and pyæmia, for I have observed when the exudation has shown itself in the form of a detached speck on the tonsils or palate, if treated at once, and the spread of the membrane checked, the patient generally recovered. I do not assert that this is always the case; hence the theory which I advance, and the practice which I pursue.

Preparations of Bark, Iron, Ammonia, Chlorate of Potash, Sulphur, Senega, Serpentaria, &c., &c., are all very good in their way, and no doubt valuable remedies for assisting expectoration, acting on the blood poison, or supporting the languishing powers of the sinking patient, but if there is a chance of removing the cause the effect might cease. The application of styptic ether has the effect, from the tanninit contains, of producing a considerable amount of contractile action on the exudation, causing it to shrivel, while it acts also on the mucous membrane from which it is exuded, or by retractile action of the muscular fibres, the membrane is liberated, the action of the ether as it gets into the larynx causes violent expulsive efforts, which assist mechanically in the expulsion of the exudation, and then there is a chance of recovery, for the membrane is not always re-exuded. Inhaling the vapour of hot water is decidedly grateful to the patient. Hydrochloric Acid and honey, or Chlorate of
Potash and honey, or Potash and infusion of Senega with honey, or a mixture of Chlorate of Potash, Bark, and honey with hot applications to the throat, strong beef tea, wine, or brandy and water, are the remedies I have most confidence in, and from which I have derived most benefit during this epidemic; but I am deeply impressed with the fact of constitutional remedies only being of little avail, for in virulent cases the disease runs its course so rapidly that the patient is hopelessly choked, unless the obstruction be removed, and air admitted to the lungs.

101 Collins-street east, August, 1868.

MEDICAL SOCIETY OF VICTORIA.

ORDINARY MONTHLY MEETING.

WEDNESDAY, AUGUST 12.

The President, Dr. Neild, in the Chair.

Present: Dr. Bird, Professor Halford, Dr. Jackson, Dr. P. Smith, Dr. Hunt, Dr. Fulton, Dr. McCarthy, Dr. Neild, Dr. Nicholls, Mr. Gillbee, Mr. Girdlestone, Mr. Blair, Dr. Thomas, Dr. Jonasson, Dr. Von Mueller, and Mr. Ralph.

NEW MEMBERS.

Dr. Hunt, of Brunswick street, Fitzroy, and Mr. H. G. Jackson, of the Stockade Lunatic Asylum, were elected members of the Society.

The following paper was then read:

ON A CASE OF THROMBOSIS OF ONE OF THE BRACHIAL VEINS IN A CASE OF PHthisIS. Recovery.

By S. D. Bird, M.D., L.R.C.P., &c.

X——, aged 26, of consumptive family, has had chest symptoms for seven years. The apices of both lungs, particularly the left, stuffed with tubercle, but no active softening going on. On June 20th, in the evening, he suddenly felt considerable sense of weight and tenderness in the hand of the right arm, which, so far as he knew, was not attributable to any over-exertion or other cause. The following day the pain was worse, and the hand was swollen and tight. He applied a rubefacient poultice of cayenne and brandy, which relieved the pain, but some swelling remained. On June 24th, after keeping the limb unusually long in a cramped position, in writing for some hours, the pain got very much worse, and the swelling reached up to the arm-pit; the pain also extended some distance down the side. The pain was not of a throbbing or lancinating character, but seemed more to be caused by the distension of
the limb. On the 28th I saw him in consultation with Dr. Motherwell, under whose care he was. The whole limb was then very oedematous and higher in temperature than the other side. There was distinct tenderness along the course of the vessels, but no pulse could be felt either in the brachial or radial artery, probably from the oedema. There was no erysipelas bluish about the skin—no swollen glands or tumour of any kind, either in the axilla or the bend of the elbow. The superficial veins of the arm and part of the chest on the affected side were turgid. There was a general feeling of tenderness and rigidity along the course of the main vessels but it was not considered advisable to manipulate the limb too much for fear of dislodging the thrombus. The treatment consisted simply of warm camomile fomentations, and keeping the limb supported on a pillow. The swelling gradually diminished, and the limb is now, July 12, reduced to its natural size; but it is difficult to trace the course of the brachial artery on the affected side, from a palpable knotty induration alongside it, which is doubtless one of the venous coittes. No pain is now experienced, but there is a sensation of tightness and “tying down” of the limb when he attempts to raise it to his head. The chest symptoms are quiescent.

The coagulation of blood in the living vessels, the formation of a clot or thrombus, is now a recognised fact in pathology, both in the venous and arterial system, and as Aitken says, “Pyæmia or phlebitis essentially begins by a real coagulation of the blood at some definite fixed point,” usually difficult to discover. The next set of phenomena which cause the constitutional symptoms characteristic of septic poisoning depend upon the softening, disintegration, and breaking up of the thrombi or clots. The clots may arise in any part of the venous system, more particularly in the limbs and in the pelvic veins. Druitt mentions a case in which the irritation of chilblains was the starting point of thrombosis of the veins in the lower limb, the clots passed upwards into the vena cava, and were found after death in the right auricle and ventricle, as a cord of fibrin, twenty inches in length. The main vein of the thigh appeared to have been the origin of the thrombus in this case, and the oedema and general appearance of the limb were similar to that of the case I have been describing. Fortunately for the individual the thrombus seems to have completely occluded the vein and arrested the upward current of blood, and in all probability it is now organized and converted into connective tissue, but the possibility of a portion still separating, or of softening taking place, with its almost certainly fatal results, cannot be lost sight of.

I do not see how the origination of the clot in this case can be connected with the phthisical condition, for on the supposition of the absorption into the pulmonary veins of any morbid material, some constitutional symptoms would doubtless have been experienced. The symptoms point to a local coagulation at the bend of the elbow, dependent on a languid circulation, and probably some unnoticed pressure on the vein. He is subject to cold extremities, and has a feeble arterial system of small calibre. The case is not in general
features at all unlike the one recorded by Druitt in the *Medical Times*, July 19, 1862, and is interesting both from its rarity and also from the facility with which the actual point of origination of the clot could be recognised.

The next paper read was one on

**TWO CASES OF LITHOTOMY, PERFORMED BY THE SEMILUNAR EXTERNAL INCISION, AS RECOMMENDED BY SIR W. FERGUSSON.**

By William Gillbee, Surgeon to the Melbourne Hospital.

Mr. President and Gentlemen,—The interest appertaining to the subjoined cases consists in the new method by which they were performed; hitherto, in all my operations for calculus in the bladder where lithotomy has been advisable, I have adopted the median method, and I am happy to say with a very fair share of success—for out of twenty-five cases so operated on, I have had but three deaths. Indeed the first fifteen were all successful, but, as very often happens, I then had a run of bad cases, losing three out of the ten which followed; still this average of less than one in eight I did not consider bad, and I had every reason to feel satisfied with the operation I had adopted. In reading a lecture, however, by Sir W. Fergusson on this subject, published in the *Lancet* of January 4th, of the current year, I was much struck with the arguments he made use of in favour of performing the operation by means of a semilunar external incision, and having repeatedly performed it on the dead subject to test its facility, I felt convinced it possessed advantages over the method previously adopted by me. I therefore determined on the first suitable case which presented itself to carry his suggestions into practice. Before however relating the particulars of the cases in which I performed this operation, I will give the special grounds which led me to adopt it. In the first place it can be performed with the same facility as the median operation, but it possesses this great advantage over it, that the semilunar external incision gives the operator more room, and as a consequence enables him more readily to introduce the finger and forceps into the bladder, and thus with greater ease to extract the stone.

For the information of those who have not had the opportunity of reading Sir W. Fergusson's lecture, I will take the liberty of quoting from it. Sir William observes: "There are two essentials in lithotomy, viz., Safety to the patient, and facility to the operator; on both of these points there are and I fear must ever be differences of opinion, but I take it upon me to say, that the method which is easiest to the surgeon, guided by anatomical and physiological considerations, must assuredly be the safest to the patient. Both these views I have always maintained, and that a free opening externally, and a limited incision internally, have been on the whole the most desirable and successful. Now the great peculiarity of this semi-
lunar incision is, that it gives such an extensive external opening beyond what in this locality any single straight line would. The gap opens something like the clasp of a purse's mouth, and the points of two or three fingers can be placed in it at once, so as to depress the anus and lower part of the rectum, and permit the knife to be freely used between the bowel and bulb, and on the lower part of the triangular ligament. With sweep after sweep of the knife in the semilunar direction a close proximity with the bladder will have been made, and now the operator may take his choice as to the steps of the future stages of the operation."

Sir William in his lecture points out the various difficulties and dangers which accompany the operation of lithotomy, and in discussing the point as to the best method to operate, so as to reduce these difficulties and dangers to a minimum, gives the preference to the median over that of the lateral, i.e., the median by the semilunar incision—not that as recommended by either Lloyd or Allarton, which here has hitherto been generally selected when that operation has been performed.

In discussing the relative value of the lateral and median operations, he states that the wound made to reach the neck of the bladder must be deeper in the former than the latter operation, and goes on to say—

"The deeper the wound the more difficult, and, I may add, the more dangerous the operation, and most notable of all the seizing and extraction of the stone are more likely to be difficult through a deep wound than a shallow one, particularly where that wound or passage for the stone is limited to one side of the perineum.

"There is no evil in the semilunar excision greater, than that of the lateral, on the contrary, there seems to me less; for in the central locality there is in reality no vessel, nerve, or part to demand the surgeon's caution. The bulb and the rectum are certainly in no great danger, and assuredly the common pubic and its perineal or scrotal are in less."

The following is his description of the operation: "The staff being introduced, the patient is to be bound and held in the ordinary way. The usual lithotomy knife, like a scalpel in a strong handle, is to be held in the right hand, with the cutting edge directly upwards; the point is then to be introduced into the skin on the right side of the perineum, midway between the anus and the tuberosity of the ischium, and a little lower than the anus. It may be inserted a quarter or half an inch deep, and by a pushing or gliding movement upwards the right side or end of the semilunar incision is made—then the curve and then the slope on the left, so that a line like that indicated here is completed."
"During the movement the knife is gradually turned round with the hand, whose radial margin from being first turned downwards is ultimately upwards. A second semilunar sweep, with its extreme ends not so deep should next be made, when the fore and middle fingers of the left hand should be pushed into the wound between the bulb and rectum with the intention of separating those parts. It will then be found that the anus and rectum can be depressed with peculiar facility. Now, too, with possibly a touch or two in the middle part of the wound, it will be found that the finger readily slips into the space between the erector penis and compressor urethrae, and the staff may be felt through the tissues between them and the membranous portion of the urethra. By a dextrous push the point of the knife may be introduced into the groove, or perhaps a little further cutting may be used to divide a portion of the triangular ligament, and part of the levator ani; or these may be divided on withdrawing the knife. The point of the blade should be pushed along, say one-half of the membranous portion of the urethra into the prostatic portion, so as to notch or cut freely the left lobe of this organ, or the latter may be done in withdrawal. Should the gorget be preferred, it may be used after the opening has been made in the membranous portion. The subsequent steps are the same as in the ordinary lateral operation, excepting that the forceps may be held more to the right, and withdrawn through the middle of the perineum instead of the left side, as in the common way. Should the stone be large, the right side of the prostate can be more readily reached through this wound than through the lateral, and the good rule of pulling obliquely downwards can be more efficiently accomplished than through a wound in the side. The after treatment is in all respects as in the usual operation, a tube being used, or not in accordance with fancy or fashion.

"The skin in front of the perineum immediately behind the scrotum being left entire, the wound is scarcely observable as the patient lies on his back. In one of my cases, a surgeon of experience, on looking at the perineum, could scarcely believe that lithotomy had been performed till he had made a closer examination."

We must allow the greatest weight to opinions founded on the experience of a gentleman whose practice has extended over thirty-five years, and who can count his 200 cases of lithotomy, and we may be certain that he would not have deviated from his usual style of operation (the lateral) without good reasons. But in the following number of the Lancet, there is a paper on lithotomy, by Mr. Erichsen, of University College, in which he states that he agrees in the main with all that has been written by Sir W. Fergusson on this subject, and says, "Although practising as a rule lateral lithotomy I have for a long time had great doubt whether it was really the best way of getting into the bladder, and more especially of extracting a large stone out of it." He also records a case in which he removed a large stone by the semilunar, or as he terms it Dupuytren's method,
but with this difference, that he used the rectangular staff and *lithotome caché*. For my part I prefer the scalpel to the latter, and think that a well educated finger is preferable to any instrument of that kind that has yet been invented.

The rectangular staff (the invention I believe of Mr. Buchanan of Glasgow) I have not used, but the three sound arguments brought forward by Mr. Erichsen in its favour, over that of the ordinary curved staff, show it to possess such advantages that I shall most certainly give it a trial.

For the notes of the two following cases, illustrative of this method I am indebted to Mr. Maunsell, my house-surgeon.

**Case 1.**—George William Langton, a strong healthy looking child, aged three years, was admitted into the Melbourne Hospital, under the care of Mr. Gillbee, suffering from all the symptoms of calculus in the bladder. Complained of great pain in the glans penis and bladder, and a consequent desire to micturate accompanied with much distress, and his urine when voided was occasionally tinged with blood.

These symptoms his mother stated had within the last few months become much aggravated, and his health consequently had begun to fail.

On passing a sound, the stone was easily detected, it was therefore deemed advisable to operate at once. Accordingly on the 9th April 1868, the operation was performed. On the previous evening a dose of castor oil had been administered, and in the morning the bowels cleared out with a soap and water enema.

The child was placed under the influence of chloroform and tied up in the usual lithotomy position, and a few ounces of tepid water injected into the bladder through a catheter, which being withdrawn a grooved staff No 7 (the largest which the parts admitted of being introduced) was passed, and the operation as recommended by Sir William Fergusson for stone performed. During the operation there was but slight haemorrhage, and the stone was easily extracted. A gum-elastic catheter was then introduced through the wound.

10th.—Slept well during the entire night; says he has no pain; the urine passes freely through the tube. Pulse normal; tongue clean. Has taken a little gruel with some bread and milk.

11th.—Does not seem quite so well to-day; tongue furred; pulse rather quick and hard; face flushed; tube removed, having been in 48 hours; wound looks healthy; ordered Haustus Ammoniae Acetatis every four hours.

12th.—Slept little last night—tongue loaded with white fur; edges red; skin hot; complains of pain over the region of the bladder. Ordered 2 ounces of wine and the mixture to be continued. To have hot fomentations applied over the whole abdomen.

13th.—Much better to-day; slept well during the night; tongue healthier; no signs of inflammation in the region of the wound; takes his food well and was ordered strong beef tea.

14th.—Tongue now perfectly clean; all pain in the abdomen has disappeared. The mixture of Acetate of Ammonia and the fomen-
tations to be discontinued. After this he had not a single bad symptom.

On the 22nd, thirteen days after the operation, he passed some of his urine through the penis, and from that time rapidly improved, and on the second of that month left the hospital cured.

The stone as you will observe is of a triangular shape—smooth on the surface, weighs grains, and consists of uric acid, principally, with a small quantity of phosphate of lime.

The next case is one which occurred in my private practice.

**Case II.**—James Armstrong, aged twenty-six, native of Ireland, had been resident in this and the neighbouring colonies for ten years; but for the last seven years in New Zealand. Always enjoyed perfect health until nearly four years ago, when he observed a frequent desire to pass water with occasional pain—his urine having a slightly muddy deposit, and traces of blood after any extra exertion.

These symptoms continued to increase, for which he underwent some treatment without any relief, and was recommended by Mr. Dermott, of Hokitika, to come to Melbourne, to place himself under my care, in hopes that an operation would give him relief.

On sounding, a stone was easily detected, evidently of very large size, and as the patient’s health had suffered severely from the excessive irritation it had occasioned, this, together with the large size of the stone, pointed out the case as evidently more suited for lithotomy than lithotrity.

Accordingly, on the 3rd June, he was operated on in the method described, viz., by the semilunar external incision, which admitted of readily grasping the stone, but some difficulty was experienced in its extraction on account of its size, and I had to re-introduce the knife and divide the right lobe of the prostate, converting it into a bilateral section, after which its removal was rendered comparatively easy.

A tube was introduced, the patient placed in bed, and an opiate left with the nurse to be administered if there should be any pain or restlessness.

4th.—Patient passed a good night, and felt so easy (in fact, much better than before the operation) that he had not taken the opiate. Pulse seventy-two, tongue clean.

5th.—Slept well, felt no uneasiness whatever. Pulse sixty-eight. Tube removed.

6th.—Going on the same. Pulse sixty. Passed urine partially by the urethra.

7th, 8th, and 9th.—The same.

10th.—Almost all the urine passed by the urethra. As the bowels were costive, a dose of castor-oil was administered, being the first medicine given during the progress of the case.

11th.—Bowels have been relieved; passed all the urine by urethra, and has perfect control over the bladder, passing his urine three times in the twelve hours.
1868.]

Discussion.

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13th.—No urine has passed by the wound since the last visit. Made water twice in the twenty-four hours. Wound almost healed. Henceforward the patient continued to improve, and greatly gained in flesh and appearance, and left for the Queensland diggings in six weeks after the operation.

The stone is of a flattened ovoid shape, somewhat similar to a turkey's egg in appearance, with a long diameter of two and half inches, and a short one of two inches; six inches in circumference, and two and a quarter ounces in weight. The outer surface was roughened with phosphatic incrustations; on section it was found to be laminated; and of its composition, Mr. Kirkland, lecturer on Chemistry at the Melbourne University, affords me the following information. The nucleus curiously enough consists of a fragment of wood.

Medical School, The University, 4.8.68.

MEMO.—The powder contained in No 1. (small calculus) consists principally of uric acid, with a small quantity of phosphate of lime.

That in No 2 (large) principally of phosphate of lime, with uric acid and a little triple phosphate.

I have not touched the calculi, which I perceive are made up in both cases of concentric layers, each layer having most likely a different composition. In order to pronounce positively upon the nature of calculi it is necessary to examine a considerable portion, (say one-half) of any specimen. I shall be happy to examine any specimens in this manner. Portions which were not used by me in the analysis would then be of considerable value for use in practical chemistry demonstrations.

J. D. KIRKLAND.

In the discussion which followed—

DR. THOMAS remarked that he was glad to see a paper of such practical importance as that which Mr. Gillbee had read brought before the society. He did not agree with Mr. Gillbee, that the operation had been devised by Sir W. Fergusson; it was, nevertheless, on that account of no less value if it succeeded than if it had been an original invention. Excision of the knee-joint and ovariotomy fell into disuse for a considerable period, owing to their being followed by such fatal results, but since they had of late years been revived in a modified form, and the after-management better understood, they had become more successful than many other recognised capital operations. This did not detract from the merit of those who brought about the revival.

Since the first operation for the removal of stone through a free perineal incision, dating as far back as the fourth century, B.C., several modes had at various times sprung up, but all seemed to have given way to the lateral and median, with their modifications. Allerton's operation performed in 1854 was a modification of the old Marian one, which had been completely thrown aside in consequence of the great mortality following it. The improvement in Allerton's method was,
that the prostate was dilated by the finger, and not by instruments, which in addition produced great laceration. The preliminary steps in both operations were similar, but the difference in the mode of dealing with the prostate had made Allerton's a very successful operation.

The operation Mr. Gillbee had described seemed very nearly allied to the bilateral, which Dupuytren performed with so much success, and one that Mr. Erichsen, in an early edition of his work, spoke of, as an operation which he considered had not received that attention which it deserved from surgeons in England. Dr. Thomas complimented Mr. Gillbee in that, when he read papers, they always tended to useful purposes, and he hoped to see him bring forward more frequently at the Society's meetings, cases of a similar character to those he had treated upon that evening.

Mr. Girdlestone also remarked upon the error of terming this a new operation. It was generally understood as Dupuytren's. He thought it a very suitable method where the stone was large. Sir Henry Thompson regarded it as Dupuytren's operation, and strongly recommended it. Mr. Erichsen had spoken highly of the angular staff, and there was no doubt it ought to come into general use, the advantage of using it being that its angle was exactly in the membranous portion of the urethra.

Professor Halford drew attention to a diagram in Professor Erichsen's work somewhat closely resembling that exhibited by Mr. Gillbee, and pointed out a discrepancy between the diagram and the text. He complimented Mr. Gillbee on his success, and expressed his concurrence in the value of the operation.

Mr. Gillbee, in reply, said it was not pretended that this was a new operation, nor did Sir W. Fergusson offer it as such. But he thought that great authority in operative surgery had given so many conclusive arguments in its favor, that he was entitled to the utmost credit for reviving it, and bringing it before the profession. He (Mr. Gillbee) had been so well convinced of its superiority to other methods, that he had determined to try it, and, having done so successfully, he had thought it only due to Sir W. Fergusson to make known through the Medical Society the result of his experiments. In answer to Professor Halford, who inquired if Mr. Gillbee thought urinary calculi more common in these colonies than in the old country, he (Mr. Gillbee) said he had not had reason to believe so, for though he himself had operated in 25 cases, they had come from all parts of the Australian group, and therefore it would not be fair to conclude that because he had had this comparatively large number, the affection was a more frequent one in Australia than England.

Dr. Bird then read a paper on a case of Pneumo-Hydrothorax, which we hope to publish in the next number.

FORTHCOMING PAPERS.

It was announced that at the next meeting of the Society, Dr. Day, of Geelong, and Dr. Thomas, of Collins-street, would each read a paper on Diphtheria.
The Third Annual Meeting of this Association took place, as announced in our last, in the Board Room of the Melbourne Hospital, on July 15th. There were present: Mr. Blair, Dr. Cutts, Mr. Rudall, Dr. Graham, Dr. Von Mueller, Dr. Martin, Dr. Neild, Mr. Knaggs, Dr. Black, Mr. Fitzgerald, the Hon. Dr. Wilkie, Mr. Gray, Dr. Bird, Mr. Gilbee, Dr. Tracy, Dr. Brownless, Dr. Jonasson, Dr. Lilienfeld. Mr. Knaggs, Vice-President, occupied the chair.

The Honorary Secretary, Dr. Neild, read the following

REPORT OF THE COMMITTEE.

To the Subscribers and Donors of the Victorian Medical Benevolent Association.

Gentlemen,—Your Committee are gratified in being able to announce at the termination of the third year of the Association, a considerable balance in hand, notwithstanding that the number of applications for relief has been greater than that of the previous year. They feel warranted in believing that the Association has reached that stage in its career as an institution which justifies the prediction of permanent success.

They think its claims should commend themselves strongly to the whole Profession of this colony. A larger measure of support would furnish the means of benefiting more permanently those who apply for relief. In the case of orphans especially, they would be glad to see the means provided for educating them, and putting them in the way of eventually earning their own livelihood. They have reason to think that the distribution of the funds hitherto has been such as to meet with the approval of the contributors, but the comparatively limited amount at your Committee's disposal has of necessity compelled them to disburse it in small sums, so as to spread the usefulness of the Association over as wide an area as possible.

An additional reason why the profession should liberally support the association, is comprised in the convenient means it offers of referring to it those applicants of whose circumstances nothing is known, and into which inquiry can so much more advantageously be made through an official channel. Your Committee are sure that several applications which have come under their notice, and which have been refused, would, if they had been dealt with by individual effort alone, have received favourable consideration, notwithstanding their possessing no claims whatever for relief; the simple explanation being that private inquiries involve more or less of personal responsibility which it is not always agreeable to be obliged to assume.

They wish to direct the attention of the profession in the country districts to the fact of several of the applications having come from persons residing out of Melbourne, and to urge this as a reason for an increased measure of support from those gentlemen residing beyond the metropolitan district. The Committee would particularly
instance Ballarat as a locality from which no contribution has been received during the past year.

The following is a list of the applications for relief that have been dealt with by the Committee.

**CASE 1.**—An L.R.C.S.I. of 1856, having first been assisted temporarily to the extent of one pound, desired further aid from the Committee. This was refused after inquiry had been made into his character, which was found to be highly unsatisfactory.

**CASE 2.**—An M.R.C.S. of 1829, and L.S.A. of 1828, who had previously applied to the Committee, but had not been assisted, was granted a sum equal to six weeks’ board and lodging at eighteen shillings per week. An additional sum of one pound was afterwards given, and subsequently, through the kindness of Dr. Cutts and Mr. Knaggs, he was procured the opportunity of entering the Benevolent Asylum, which he declined.

**CASE 3.**—An M.R.C.S. of 1861, gave the following account of himself. He had served in the late American war, and had subsequently engaged in private practice in the States. He returned to England, in consequence of having had two attacks of fever, taking with him his wife, whom he had married in New Orleans. He was afterwards engaged as surgeon to one of the mail steamers, and made three voyages from Liverpool to New York. He then commenced private practice in England, then came to this colony, leaving his wife in the old country, and on arrival here found himself destitute and so applied for a loan from the Association. Inquiry however having been made of the agents of the vessel in which he came out as surgeon, a very bad character was given of him, and his application was refused.

**CASE 4.**—A gentleman whose qualification was unknown, but whose name was on the old register. He had formerly practised successfully at one of the inland towns of the colony. He then went home, then returned to Victoria, and shortly removed to New Zealand, where he at first succeeded tolerably well, but through intemperance he became reduced, and at the time of his application he was entirely destitute and obviously suffering from brain disease. Three guineas were awarded to the friends of this applicant as a supplement to a local fund that was being raised for his relief, and fourteen shillings were paid for railway fare.

**CASE 5.**—An L.R.C.S., Ed. This person gave but an unsatisfactory account of himself, and furnished references which, on application, were found not to be genuine. A few shillings had been given to him for temporary relief, and nothing further was granted.

**CASE 6.**—An L.S.A. of 1833, who had on two previous occasions been assisted by the Committee, was awarded six pounds, the circumstances being of an especially urgent character.

**CASE 7.**—The widow of an L.R.C.S. Ed., of 1846, who had practised in Melbourne and on the gold-fields from 1853 to 1860.
This case, on inquiry, was found to be a particularly deserving one, and the applicant was granted the sum of three pounds, to enable her to commence a small school in one of the suburbs.

**Case 8.**—The widow of an L.S.A., lately deceased, who had practised in a locality about twenty miles from Melbourne. The widow had been left with five children, the youngest only five months old. She was granted two pounds ten shillings to assist in enabling her to open a school.

**Case 9.**—An M.R.C.S.E. of 1865, and L.R.C.P. Ed. of 1866, who had lately practised in New Zealand, applied for temporary assistance, pending the arrival of a sum of money from that colony. He was granted a loan of two pounds five shillings, part of which he subsequently repaid, and this loan afterwards enabled him to apply for a situation as assistant surgeon to one of the hospitals on the gold-fields, which he obtained and still holds.

**Case 10.**—The daughter of a deceased M.R.C.S.E., formerly practising in one of the suburbs, was granted five pounds to enable her to pursue her studies in preparing for examination as a teacher under the Common Schools Act.

**Case 11.**—The widow of an M.D., Glas., 1830, lately deceased (case 6 of first report), was granted ten pounds to enable her to open a boarding-house in one of the suburbs.

**Case 12.**—The wife of an M.R.C.S.E., of 1838, practising in Tasmania. The applicant stated that her husband’s habits and violent temper rendered it impossible for her to live with him. She had grown-up children in that colony, but their means were only of a limited kind. She was desirous of obtaining a situation, and only required some temporary assistance until she could do this. This applicant was extremely well-recommended, and she produced letters which bore most favourable testimony to her merits and supported the truth of her statements. It appeared that her husband had once been the resident-surgeon to the Toronto Hospital, Canada, and had afterwards served in the Crimean war, and that his dissolute habits had been chiefly contracted since his residence in Tasmania. As he had never practised in Victoria, however, the Committee declined to grant the applicant any pecuniary assistance, but through the endeavours made by the Committee she obtained an appointment as housekeeper to a semi-public institution.

**Case 13.**—The widow of an M.B. (T.C.D.), &c., long practising in Melbourne. Application was made to the Committee for a contribution to a fund being raised for her relief. The matter was postponed for further consideration.

**Case 14.**—An M.R.C.S.E., lately practising in an up-country district, stated that he had lost or been robbed of his purse and had not the means of proceeding from Melbourne to a locality where he contemplated practising. He was granted a loan of two pounds ten shillings.
The Committee have met nine times, and the attendance has been as follows:

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Dr. Cutts</td>
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<tr>
<td>Mr. Blair</td>
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<td>Mr. Knaggs</td>
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<td>Dr. Neild</td>
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<td>Dr. Martin</td>
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<tr>
<td>Mr. Gillbee</td>
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<td>Dr. Wilkie</td>
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<tr>
<td>Dr. McCrea</td>
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<tr>
<td>Dr. Howitt</td>
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On the motion of Mr. Gillbee, seconded by Dr. Tracy, the report was adopted.

The Honorary Treasurer, Dr. Cutts, then read the following cash account for the year preceding:

TREASURER IN ACCOUNT WITH THE VICTORIAN MEDICAL BENEVOLENT ASSOCIATION FOR THE YEAR ENDING JUNE 30, 1868.

\[
\begin{array}{lrr}
\text{TREASURER} & \text{IN ACCOUNT WITH THE VICTORIAN MEDICAL} \\
& \text{BENEVOLENT ASSOCIATION FOR THE YEAR} \\
& \text{ENDING JUNE 30, 1868.} \\
\hline
\text{Dr.} & \\
\text{To Subscriptions received during 1867-8, as per list} & £37 1 0 \\
\text{Donations, do.} & 15 15 0 \\
\text{Interest on Government Debentures} & 9 0 0 \\
\text{Balance brought from previous year} & 136 17 7 \\
\hline
\text{£248 13 7} & \\
\hline
\text{Cr.} & \\
\text{By Grants} & £41 10 0 \\
\text{Commission to Collector} & 3 7 0 \\
\text{Premium on purchase of Government Debentures} & 2 8 6 \\
\text{Stamps, Stationery, and Advertising} & 2 14 0 \\
\text{Collecting Cheques} & 0 5 0 \\
\text{Stillwell and Knight, for printing report} & 2 0 0 \\
\hline
\text{£52 4 6} & \\
\hline
\text{Government Debentures} & £175 0 0 \\
\text{Cash in Bank} & 21 9 1 \\
\hline
\text{£196 9 1} & \\
\hline
\end{array}
\]

On the motion of Dr. Bird, seconded by Mr. Fitzgerald, the Treasurer's account was adopted.

Some conversation followed, in which surprise was expressed that the country members of the profession had contributed so little to the funds of the Association, and the opinion was given that this lack of co-operation was probably due to the fact of there not being branch organizations in the inland towns. It was eventually resolved, on the motion of Dr. Tracy, seconded by Dr. Brownless, that local secretaries be appointed in the country districts to co-operate with the Committee in carrying out the purposes of the Association.
ELECTION OF OFFICERS.

The election of officers for the ensuing year was then proceeded with, the following being the result:—

President, Dr. Howitt; Vice-Presidents, Mr. Knaggs and Dr. Von Mueller; Treasurer, Dr. Cutts; Joint Honorary Secretaries, Dr. Neild and Dr. Martin; Ordinary Members of Committee, Mr. Gillbee, the Hon. Dr. Wilkie, Dr. Black, and Dr. Tracy.

LIST OF CONTRIBUTIONS.

The following is a list of the contributions for the past year:—

SUBSCRIPTIONS.

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<td>Galbraith, James</td>
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DONATIONS.

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<td>Knaggs, Mr.</td>
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<td>Martin, Dr.</td>
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<td>Paley, Mr.</td>
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A few days ago a man was killed in one of the outskirts of this city, by the fall of a quantity of earth upon him. As is usual on such occasions, there was an outcry for medical aid, and half a dozen frantic people rushed in various directions for any or every medical man that could be found. There happened, at the time, to be passing near the place, one of the physicians of a public institution in the neighbourhood, and a policeman, somewhat more frantic than the rest of the excited messengers, seized his horse by the bridle, and insisted upon taking him to the scene of the accident. His refusal to be hailed off in this peremptory manner evoked a good deal of official insolence from the constable, who, on being threatened with a charge of exceeding his duty, defied the medical profession all and sundry, and declared himself to be the best judge of what was his duty. The medical gentleman so summoned, however, refused to go, and subsequently reported the affair to the superintendent of police, by whom it is now under investigation.

This case is highly important to the whole profession, inasmuch as it involves the question of whether a medical man is obliged at all times and under any circumstances whatever, to give his time to anybody who chooses to demand his services, utterly irrespective of the prospect of remuneration. There prevails in the public mind an impression, that he is thus obligated, and that he may not refuse to comply with such summonses on pain of himself being severely dealt with by the law. But even those persons who are aware that the law imposes no such obligation, think that on the principle of humanity and benevolence the medical man should always hold himself in readiness to respond to such calls. In their minds he is apparently judged on different principles from those which are applied to every other section of the community. The knowledge and skill it may have taken him many years and cost much money to obtain, are, according to these reasoners, held only in trust to be employed in the cause of universal philanthropy. They will deem him god-like so long as he will fly unconditionally to every call of suffering humanity, and if he
be but content to carry out practically the very old proverb which heads this article, and never to dream of payment for his labour, he may perhaps enjoy, in a high degree, the good opinion of those who thus condescend to ask him for his services. But nothing short of the promptest readiness to obey every summons and get nothing for obeying it, will satisfy these benevolence-mongers. They will compliment a medical man on his skill, his amiability, and his success, but they will give him no fee; and if he should be sordid enough to ask for one, or to refuse to go when he is required until some assurance is given that he will receive a fee, he is at once denounced as an unfeeling person, dead to all the generous impulses which move the high-souled and benevolent.

It has come therefore to be necessary for medical men, as a rule, to refuse to attend on an emergency, unless with likelihood of payment. The inconvenience, the waste of time, the actual loss of money, and not seldom a disastrous amount of responsibility, are the only acknowledgments they very frequently get, for their readiness to serve emergency patients. It is necessary that this unreasonable and altogether mistaken estimate of the obligations of medical men towards the public should be corrected, and it will form one of the functions of the contemplated Medico-Ethical Society to accomplish this necessary change.

CORRESPONDENCE.

ON THE NATURE OR ESSENCE OF DISEASE IN VICTORIA.

To the Editor of the Australian Medical Journal.

Sir,—I have read the series of papers published under the above title in recent numbers of the Journal, expecting to derive some information on the subject proposed for discussion; I have however been disappointed, for beyond a few introductory statements, no reference is made to the nature or essence of disease in Victoria. The title appears to have been bestowed on the lucus a non lucendo principle. The writer, Dr. Clutterbuck, in entering on his task expresses his diffidence, being aware, as he states, that "his views are at variance with the prevailing doctrines of the day; these implying a distinctiveness of character in diseases of this colony totally different in their nature from those occurring at home, &c." Then follows the following statement: "It is assumed, however, that a specific agent is in operation in Victoria, predisposing or giving rise to new forms of disease." Where, or by whom this assumption has
been made, I have been unable to discover, but I fully coincide with Dr. Clutterbuck that it is "merely supposition, unsupported by proof." I have no faith in the operation of any specific agent, limited in its influence to this colony, but I am one of those who believe that the diseases met with here are of an asthenic character even at the onset, or they speedily become so, more especially when depressing treatment is had recourse to. Inflammation of internal organs, or even of serous membranes, is seldom accompanied by constitutional symptoms of that active or sthenic character that indicate general blood-letting. On the contrary, the necessity of supporting the strength during the progress of disease is often unmistakably enforced by the rapid supervention of prostration.

The human constitution is altered or influenced by a variety of causes acting from without or from within, and it may readily be acknowledged that morbid action, or the phenomena of disease, are alike susceptible of modification, depending on the constitutional strength, habit of body, previous state of health, &c.

It is not my intention to review minutely the essays of Dr. Clutterbuck, but I wish to notice some statements that appear to me not quite orthodox.

The system of medicine propounded has at least the merit of simplicity, and may be fitly expressed in few words as the following effect: "Almost all diseases, fever not excepted, are included under the general term, inflammation," and blood-letting is the sovereign remedy. Such, in fact, is the doctrine unfolded. In advocating the free use of blood-letting, Dr. Clutterbuck has been unfortunate in directing attention particularly to fever and dysentery as diseases demanding depletion. He might have advocated blood-letting with some slight show of reason, had he selected certain inflammatory diseases in illustration, but I think that at the present day he will scarcely succeed in convincing his professional brethren that the form of fever prevalent here is a local inflammation, involving the brain and its membranes, which may be arrested by blood-letting, or that dysentery is a disease amenable to the same treatment.

But let us learn of Dr. Clutterbuck the symptom and sign which in his opinion offer the most reliable indications of inflammation, and to do him justice, I quote his own words: "The appearance of a coated state of the tongue is characteristic, and one of the ordinary signs of inflammation." Again, "if foulness of the tongue be, as I take it, one of the surest indications of inflammation, its twin sister is to be recognised by a buffy, or sicy, or inverted edges of the crassamentum, or solid portion of the blood when drawn." I cannot allow that either the condition of the tongue, or appearance of the crassamentum, or even both together, are characteristic of inflammation. A foul or furred tongue is often present where no inflammation exists. I need only instance this state of the tongue as occurring in cases of chronic dyspepsia, or in the case of those suffering from temporary derangement of the digestive organs, or who may be in the habit of supping late, or smoking and drinking before retiring to bed.
Again, the buffed and cupped appearance of the clot cannot be accepted as “one of the surest indications of inflammation,” neither can any value be attached to it “as a means of diagnosis,” although Dr. Clutterbuck is in the habit of having recourse to blood-letting for that purpose. It is an ascertained fact that the blood is buffed and cupped in cases where blood-letting is neither indicated nor warranted, as in pregnancy, phthisis, typhus and other fevers. Besides it is found that the fibrin of the blood (to the presence of which in increased quantity the buffed and cupped appearance of the blood is attributed) increases relatively to the red corpuscles with the number of blood-lettings in a state of health, as well as when inflammation is present. Blood-letting is not only powerless to decrease it, but it actually tends to increase it. When Dr. Clutterbuck comes to describe the state of the blood in dysentery, he allows that in the early stage of that disease no morbid change will possibly be visible in its solid portion; “neither buff may appear on the surface of the crassamentum, nor its edge be incurvated or cupped.” It is only when venesection is repeated that the clot exhibits the buffed appearance. What value, I ask, can be attached to it as a means of diagnosis, seeing the same result follows repeated venesection in a state of health.

To show the peculiar views of Dr. Clutterbuck in reference to dysentery and its treatment, I make the following quotations: “Distinctions have been drawn between acute and sub-acute, chronic, indolent, or asthenic dysentery, arbitrary terms, seemingly implying a distinctiveness of species, and as being prohibitory of blood-letting; the degree of a thing, however, makes no difference in its nature. As then ulceration of the intestines, the sole effect of inflammation and of no other cause, is a condition not easily recognised during life, and which is so destructive of it, is it not better to assume danger, where perhaps none may exist, and to adopt at the onset a decided and vigorous anti-phlogistic treatment, than to be lulled into a false security (which perhaps mild symptoms might inspire), and to treat the affection by mere placebos.” Again: “At the commencement of this affection, the pulse being neither strong nor frequent, the propriety of adopting blood-letting has been questioned; but however apparently languid the circulation, if the tongue be found coated, which indeed it always is, no evacuation can be more safely resorted to.”

Such is the teaching of Dr. Clutterbuck, and in designating his views peculiar, I use a mild term. I might also add, they are erroneous. Even the most ardent advocates of depletion allow that blood-letting must be regulated by the constitutional strength of the patient, the violence of the inflammatory symptoms, and the period or stage of disease.

* The formation of the buffy coat is said to be due to the tendency of the red corpuscles to cohere rapidly, or become aggregated in rouleaux, and to sink below the surface before the coagulation of the fibrin in which the white corpuscles become entangled takes place.
A strong full or incompressible pulse has been considered an indication for blood-letting, while asthenic symptoms, the absence of constitutional disturbance or high febrile action, and the condition of pulse now mentioned, have been supposed to contra-indicate the employment of blood-letting.

What, I would, ask are the objects for which general blood-letting is employed? Certainly to diminish the force of the circulation by controlling or weakening the heart's action, to lessen the quantity of blood in the system, and to cause derivation from the part affected. In a case, therefore, where "the pulse is neither strong nor frequent," and the circulation is languid, whence the necessity for blood-letting? or where ulceration is present, what benefit can be expected?

I cannot easily reconcile the advocacy of general blood-letting with the following observation: "Blood drawn in this manner," that is by leeches, "induces positive weakness of system, a circumstance at all times to be dreaded as unfavourable to a speedy recovery." Is not general blood-letting much more liable to induce debility, and retard recovery, by diminishing the amount of blood in the system, and impoverishing what is left? Venesection will be powerless to influence local inflammation unless it affects the heart's action, but the local application of leeches acts directly on the seat of inflammation, and so relieves congestion without influencing the system, and causing debility to the same extent.

But dysentery is a disease in which depression or prostration rapidly supervenes, even in cases where the symptoms have been apparently acute and violent at the onset. On that account general blood-letting has been considered unnecessary, and even injurious, and it has accordingly fallen into disuse. Recoveries from that disease are said to be increased since blood-letting was abandoned.

I come now to notice two cases of dysentery selected by Dr. Clutterbuck from his notes, in which there was an absence of acute symptoms, and yet both patients died on the fifth day, and yet he innocently adds, "had blood-letting been adopted within a day or two of the attack, it is just probable a fatal issue might have been averted." From the description and mode of termination of the cases, and especially from the post mortem appearances in the case examined, I have no hesitation in saying that neither was a case of dysentery. Both were doubtless instances of a mild form of enteric or typhoid fever, the patients being able to move about until an advanced stage of the disease. Rarely is ulceration of the small intestine found in dysentery, and I have never seen or heard of a case of pure dysentery terminating by perforation on the fifth day, or indeed at any stage of the disease. When the muscular and serous coats of the intestine become implicated, exudation of lymph and agglutination to the surrounding parts take place, thus preventing perforation. I have, however, met with peritonitis resulting from perforation, and occurring under very similar circumstances, in more than one case in hospital practice. The patients have felt unwell, and suffered from a relaxed state of the bowels,
but have been able to move about and attend to their usual duties, until they were suddenly seized with symptoms of peritonitis, and became collapsed. In these cases, post mortem examination has revealed the characteristic lesions of Peyer's patches, and of the solitary glands which are pathognomonic of enteric fever.

I pass on to notice Dr. Clutterbuck's dogma in regard to fever, and I am astonished to find that an attempt is made to revive and vindicate a doctrine long ago exploded. Dr. J. B. Clutterbuck is desirous of rescuing from oblivion, or resuscitating the doctrine of his ancestor, Dr. Henry Clutterbuck, for he states plainly, "his theory is the ground-work of the present sketch." He is, however, over credulous in supposing that the work of "Clutterbuck on Fever," "still exerts considerable influence on the minds of a large section of practitioners in all parts of the world." Fifty years ago, such a statement might have been accepted as an approximation to the truth. When Clutterbuck first advanced the doctrine that fever was essentially a local affection, and that its seat was in the brain, it gained not a few adherents in England, owing to the frequent occurrence of head symptoms in the fever then prevalent, and the occasional observance of inflammatory appearances in fatal cases.

While, however, this doctrine found favour in England, Broussais advanced the theory that the gastro-intestinal mucous membrane was the seat of fever, and his countrymen embraced that doctrine, finding that structural lesions were more frequently met with in it, than in the brain.

Other theories were also advanced as to the seat of fever. By-and-by British physicians found that the fevers of Great Britain presented a great variety of type, sometimes inflammatory, sometimes typhoid, occasionally with symptoms of local inflammatory action in the head, chest, or bowels during life, and corresponding lesions after death, and often without any appreciable sign of local inflammation during life, or any morbid appearance after death. They were thus led to conclude, that fever was a primary or idiopathic affection, and that the local lesions assumed to be its source, were in reality only secondary. Then physicians came to be divided into two classes, termed essentialists and non-essentialists; the essentialists believing that fever was a primary or idiopathic disease, the non-essentialists denying the existence of primary or idiopathic fever, and attributing fever to some local lesion.

All continued fevers were included in one class or genus comprising three different varieties, synocha, synochus; and typhus, for the classification of Cullen was followed by most authors with but little variation. The synocha of Cullen has now disappeared, and the synochus has been transformed into the typhoid of Jenner, to whom we are indebted for having brought order out of confusion.

I shall not trouble your readers with the classification of continued fevers that now obtains, as it is doubtless well known; but if
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not, it can be readily ascertained by reference to any of the standard medical works of the day.

The sketch given by Dr. Clutterbuck of fever, as it occurs in this colony, is certainly not consistent with my experience, and I am driven to the conclusion, that the form of fever met with in Maldon is different from that prevalent in Melbourne. "The true idiopathic fever, which sometimes ends fatally within a week, or even sooner," is not met with in Melbourne. The form of fever seen in Melbourne, and which may be considered endemic, is enteric or typhoid, for although the characteristic symptoms and signs are not always well marked, the intestinal lesions ("the anatomical sign") are found to exist when opportunity for post mortem examination offers. It is usually known as "Colonial Fever," or rather it was at one time so distinguished, and was supposed to be a fever sui generis, different from those met with elsewhere. In fact, it was regarded as the "seasoning fever," incidental to the climate—a specious fallacy.

In enumerating the causes of fever, I find Dr. Clutterbuck includes the following: "defective drainage in the city of Melbourne, ill-ventilated rooms, or rather no ventilation, in the majority of sleeping apartments; the huddling together of numbers of persons in one room in our public hospitals." How, I would ask, do these causes induce fever, seeing that in his opinion it consists of inflammation of the brain—cerebritis? Again, what does he imply by applying the term "idiopathic" to fever, seeing that he regards fever as a strictly local affection followed by pyrexia or symptomatic fever. I must dissent in toto from the treatment of fever by general blood-letting and purgatives recommended by Dr. Clutterbuck. I do not believe in fever being arrested by blood-letting, but I can readily understand why fever should prove fatal at an early stage, when the opinion is entertained that "a patient's safety depends principally upon boldness and decision of practice, in the employment of strictly antiphlogistic measures—no half ones will suffice;" and that "taking away six or sixteen ounces of blood from the arm, is a matter of little moment."

I have no hesitation in saying, from my experience of an opposite plan of treatment, that the patient's safety lies in adopting a totally different course—in husbarding his strength, and supporting the vital power. Blood-letting is powerless to cut short fever, and it causes exhaustion or prostration, the source of danger when fever is not accompanied by any complication.

Previously to the appearance of Dr. Clutterbuck's lucubrations in the pages of the Journal, I was of opinion that the treatment of fever by general blood-letting was a thing of the past. Judge of my astonishment to find that an advocate of that obsolete system resided in Victoria. Indeed, I entertained the idea that the lancet was rarely used, even in acute inflammation of internal organs or serous membranes, in which its use might be advocated with more show of reason. Inflammatory diseases are not in general attended with high constitutional excitement in this colony, and medical
practitioners have in consequence been led to abandon general
blood-letting. I agree, however, with the following statement of Dr
Clutterbuck: "to test the soundness of any doctrine, a long series of
experiments are needed to prove it to be so, or otherwise." It is only
by proceeding in this way that the value of blood-letting, or indeed
of any remedial agent, can be successfully scrutinized and deter-
mined." Few, I apprehend, would be bold enough to conduct or
institute experiments with the view of testing the tolerance of the
system to blood-letting in this colony under different diseases, but
possibly Dr. Clutterbuck may be able to furnish valuable data, by
publishing the result of his experience. The table drawn up by Dr.
Marshall Hall some forty years ago, representing the augmented and
diminished tolerance of the system to the loss of blood in different
diseases, affords us the means of comparison. He determined what
he terms "healthy tolerance" of blood-letting, by placing persons in
health in the erect posture and bleeding to incipient syncope. By
adopting similar measures in the case of those labouring under
disease, he ascertained that in certain diseases the tolerance of
blood-letting was augmented, while in others it was diminished, less
than the tolerance of health. It would be very interesting to know
the tolerance of blood-letting in different diseases at the present
day, and more especially in this colony, to ascertain how far the
experience of Dr. Clutterbuck in regard to the tolerance of blood-
letting agrees with the recorded experience of Dr. Marshall Hall. I
shall look for the information with breathless expectation.

I cannot conclude without referring to the remarkable case placed
on record by Dr. Clutterbuck "as an illustration of the impunity
with which blood may be abstracted from the human body." It
forms a fitting climax to the preceding essays. It can scarcely be
accepted as evidence of the efficacy of blood-letting in disease; but
it exhibits the tolerance of the human system to the loss of blood
when only a small quantity, not exceeding six ounces, is let at one
time, for it appears that Sophia Graafe having been bled and cupped
to that amount at short intervals, during a period of thirteen years,
only exhibited "extreme pallor" and died "but slightly emaciated."

I am, Sir, yours, &c.,

JAMES ROBERTSON, M.D.

Victoria Street, 7th August, 1868.

PROFESSIONAL HONOUR.

To the Editor of the Australian Medical Journal.

Sir,—I have lately had brought under my notice a very un-
pleasant and humiliating fact, which, unless proved by convincing
evidence to be so, I should not have believed. It is, that a legally
qualified Medical Practitioner, residing in one of the suburbs, is in
the habit of coming out to consult (it is not right to say professionally)
with a quack living in this neighbourhood. I hear also, on what I
cannot but consider as good authority, that the same gentleman comes in at the last moment and signs certificates of death for patients, when the latter individual has been attending. It is needless to ask what respect we, as a profession, can expect to receive from the public, if conduct so degrading to us as a body, reducing us, as it were, to the level of a quack, is continued by one of our number, and silently approved of by the rest.

It seems to me to be high time there were an Ethical Society amongst us in working order, sufficiently influential to cause the discontinuance of such proceedings; and for my part, I may be allowed perhaps to say, I very much hope that the movement now on foot for the establishment of a society of the kind will prove, in spite of difficulties, to be a practicable undertaking, and issue in final success.

I am, sir, yours obediently,

JOHN FREDERIC COBB, M.R.C.S., Eng.

Brunswick, July, 15, 1868.

THE CASE OF SOPHIA GRAAFE.

To the Editor of the Australian Medical Journal.

Sir,—I remember well the person Sophia Graafe, mentioned by Dr. J. B. Clutterbuck. She was still alive in 1846, an outpatient under Mr. Salmon, and to the best of my recollection was regularly bled every Monday morning, so that another 1500 oz. of blood may be added to the loss. She was lancet-marked wherever a good vein existed.

I am, sir, your obedient servant,

22nd July, 1868.

GEORGE B. HALFORD.

GRATUITOUS PRESCRIBING.

To the Editor of the Australian Medical Journal.

Sir,—Will you have the goodness to inform me if the practice of providing clergymen with professional attendance and (in many cases) medicine gratuitously, is a general one? If it is so, I am at a loss to discover on what principle of courtesy or justice it is based. I am in the habit of contributing to the support of the church to which I belong, and I do not think it fair that I should be expected to visit, prescribe, and to provide medicine for my clergyman and his family, without remuneration. Nevertheless I have reason to believe that any exhibition of conservatism in the shape of a bill would be looked on as an innovation. If the system is recognised by the profession generally, it appears to me to be a fit subject for the consideration of the committee appointed to draw up rules for the projected Medico-Ethical Society.

I am, sir, yours, &c.,

RUSTICUS.
LOCAL TOPICS.

The following gentlemen registered their qualifications at the last meeting of the Medical Board:—William Frederick Ewington, Gisborne, M.R.C.S.E. 1853, L.S.A. Lond. 1861; John Caldwell, Raywood, M.R.C.S.E. 1834, Ext. L. R.C.P. Lond. 1841; Henry Jackson, Melbourne Hospital, L. et L.M.R.C.S. Ed. 1858, L.R.C.P. Ed. 1859; Thomas Lang, Wanganella, Deniliquin, N. S. Wales, L.R.C.S. Ed. 1889; William Bainbridge, Alexandra, M.R.C.S.E. 1833, L.S.A. Lond. 1833. The above have all been previously included in former registers.

The following public appointments have lately been made:—Vaccinators: Mr. Richard Brown, L.F.P.S.G. and L.S.A., for the district of Buninyong, vice Mr. Casey resigned; Mr. George Frederick Barnes, M.R.C.S.E., for the district of Woodend, vice Mr. S. Smith resigned.

Mr. Goldie, L.R.C.S.E., late of Port Albert, Gipps Land, has been appointed surgeon-superintendent of the Sunbury Industrial Schools, lately vacant by the resignation of Dr. Kennedy. Previous to leaving Port Albert, Mr. Goldie was presented with a gold watch and a complimentary address by the Rev. Mr. Byrne, on behalf of the Roman Catholic residents in Gipps Land.

Mr. Stokes and Mr. Jackson, the two recently appointed Resident Surgeons to the Melbourne Hospital, have for several weeks been disabled from duty by an attack of scarlatina. Mr. O. V. Lawrence, and Mr. T. R. Ashworth of the University Medical School, have been acting temporarily in their place.

Dr. Bland of Sydney died on Tuesday July 21st, at the age of seventy-nine. From a biographical notice in one of the Sydney papers, of this greatly respected member of the profession we have the following:—"William Bland was a native of London, and the son of a medical practitioner of celebrity in that city. Having undergone the necessary preparation, he entered the Royal Navy as a surgeon, which position he held for some time, till, sailing up the Persian Gulf, a quarrel ensued between him and the purser of the ship. The latter challenged Dr. Bland; they fought, and the purser fell at the first shot. Bland’s second in this affair was Mr. Randall, the first lieutenant of the ship. They were both tried at Calcutta, and found guilty of manslaughter. Bland was sentenced to transportation for seven years and Randall for eight. In pursuance of this sentence, Dr. Bland arrived in New South Wales in the year 1814; but was shortly afterwards emancipated and resumed the practice of his profession. In 1817 he married the daughter of a gentleman engaged in missionary labours. He was not happy in his married life, and some time afterwards was separated from his wife. In 1818 he was sentenced to twelve months’ imprisonment for a libel upon Governor Macquarie. From that time to 1843 he devoted himself to his profession, his only connection with politics being that he acted as corresponding member to the Patriotic Association. In 1843 he and Mr. Wentworth were elected to the Legislative Council of New South Wales, as representatives for Sydney. Dr. Bland was not successful as a debater; but was appointed to the nominee Legislative Council, which position he held until a short time before his death. Dr. Bland enjoyed a very high reputation for benevolence and ability."
The Committee of the Ararat Hospital have adopted the system of paying patients, and it is reported to "work well."

The Hobart Town Mercury hears that Mr. W. G. Maddox, M.R.C.S., L.R.C.P., son of the late Dr. Maddox, has been appointed Assistant-surgeon of the Government Lunatic Asylum, Broadmoor, Berkshire.

At the Sydney Criminal Sessions held on the 10th inst. Thomas Gibson Anderson, surgeon, was convicted of stealing diamond rings, and sentenced to three years imprisonment.

We have received from Mr. R. Appleton, Pharmaceutical Chemist, of 203 Bourke St. East, a sample of Charcoal Lozenges. Those who use charcoal for gastric affections, however, had much better take it uncombined with the agreeable adjuncts used for giving it the trochee form, inasmuch as the therapeutic qualities of carbon are impaired by its being made up into a sweetmeat.

MARRIAGE.

Atkinson—Morton.—On the 1st August, at Sandhurst, Harry Leigh Atkinson, M.D., to Christiana, youngest daughter of the late Captain John Morton.

NOTICES TO CORRESPONDENTS.

Communications have been received from Mr. Gillbee, Dr. Robertson, Dr. Bird, Mr. Blair, Mr. Cobb, Professor Halford, Dr. Mannsell, "Rusticus," Dr. Murray, Dr. Von Mueller, Dr. Heily, Dr. Alfred Shaw, Mr. Trimmer (Secretary R.C.S.E.), Mr. Chatto (Librarian R.C.S.E.)

The following publications have been received: "The Lancet," 1 No. "The Medical Press and Circular," 4 Nos.
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