

viously unprotected. This has been clearly shown by Dr. Seaton in his article on Re-vaccination. Neither is it safe to infer that lymph which is capable of producing occasionally a typical vesicle is necessarily sufficiently active to ensure at the same time the constitutional effects which are essential to thorough protection. All that is really known to rest upon a secure basis of ascertained facts is, first that primary lymph, carefully selected in accordance with Jenner's directions, has immense protective power. Any important deviation from his rules is invariably followed, sooner or later, by deterioration of the lymph; and, although this is first manifested by the modification of the vesicles, it may not be discovered until much mischief has been done by the propagation of a virus of inferior quality. The actual results to be obtained from the use of the lymph of revaccination are yet to be shown, as we have no reliable data of sufficient extent to justify an inference, and therefore it would seem at least imprudent, in so important a question, to substitute for the Jennerian lymph, which has stood the test of nearly a century, that which has scarcely been used or thought of more than a few months.

## ASSOCIATION INTELLIGENCE.

### BATH AND BRISTOL BRANCH.

THE fifth ordinary meeting of this Branch will be held at the Royal Hotel, College Green, Bristol, on Thursday, April 13th, at 7 P.M.; CHARLES BLEECK, Esq., President, in the Chair.

Papers are promised by Dr. E. L. Fox, Dr. W. Budd, Mr. Leonard, Mr. Tibbits, and Mr. Dowson.

R. S. FOWLER, }  
E. C. BOARD, } *Honorary Secretaries.*

Bristol, March 29th, 1871.

### SOUTH-EASTERN BRANCH: WEST SUSSEX DISTRICT MEDICAL MEETINGS.

A MEETING of the members of the above district will be held at the Steyne Hotel, Worthing, on Tuesday, April 18th, at 4.15 P.M.; H. COLLET, M.D., in the Chair.

Dinner will be provided at 5.45 P.M. precisely. Charge, 5s., exclusive of wine.

All members of the South-Eastern Branch are entitled to attend, and to introduce friends.

Gentlemen who wish to make communications at the meeting, are requested to inform me *at once*, in order that a notice thereof may be included in the circular convening the meeting.

WM. J. HARRIS, *Honorary Secretary.*

13, Marine Parade, Worthing, March 20th, 1871.

### METROPOLITAN COUNTIES BRANCH.

AN ordinary meeting of this Branch will be held at the Charing Cross Hotel, on Friday, April 21st, at 8 P.M.; when Dr. E. C. SEATON will open a discussion on Some of the Lessons to be derived from the present Epidemic of Small-pox.

A. P. STEWART, M.D. }  
ALEXANDER HENRY, M.D. } *Honorary Secretaries.*

London, March 29th, 1871.

### CUMBERLAND AND WESTMORLAND BRANCH.

THE spring meeting of the above Branch will be held at Kendal, on Wednesday, May 3rd, 1871; THOMAS F. L'ANSON, M.D., President, in the Chair.

Gentlemen intending to be present, or to read papers, are requested to communicate with the Secretary without delay.

HENRY BARNES, M.D., *Honorary Secretary.*

Carlisle, March 29th, 1871.

### CAMBRIDGE AND HUNTINGDONSHIRE BRANCH.

A MEETING of the above Branch will be held at the County Hospital, Huntingdon, on Wednesday, May 3rd, at 2 P.M.; MICHAEL FOSTER, Esq., in the Chair.

Dinner at the George Hotel at 5 P.M. Tickets 13s. each.

Gentlemen intending to read papers, or to be present at the dinner, are requested to communicate with the Honorary Secretary.

J. B. BRADBURY, M.D., *Honorary Secretary.*

Corpus Buildings, Cambridge, April 1st, 1871.

## REPORTS OF SOCIETIES.

### ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, MARCH 28TH, 1871.

JOHN BIRKETT, Esq., Treasurer, in the Chair.

ON THE CLASSIFICATION AND TABULATION OF INJURIES AND SURGICAL OPERATIONS IN TIME OF WAR. BY DEPUTY INSPECTOR-GENERAL T. LONGMORE, C.B.

AFTER adverting to the practical value which attaches to statistical information derived from surgical experience in time of war, the author proceeded to consider the subject of his paper under five separate heads. Under the first head, he remarked upon what had been done in this country in respect to the nomenclature and allocation of gunshot injuries in general nosological classification, more particularly commenting on the changes of names and arrangement which have been introduced by the Committee appointed by the Royal College of Physicians of London to draw up the Nomenclature of Diseases which appeared in the year 1868. In the second division of the paper, the author gave an account of the special classification and tabulation of the statistics of particular gunshot injuries and their treatment in time of war adopted in the British military service; and afterwards of the official systems employed in the United States and France. He also remarked upon the absence of any corresponding official system of classification in the army medical returns of Germany. In the third section of the paper, the question was considered how far the tabular statistics contained in the official records of campaigns published in this country, in the United States, and France, can be justly compared with each other; and the author arrived at the conclusion that no such fair comparisons can be instituted under present circumstances. The fourth division of the paper was devoted to a study of the relative merits of the British, French, and United States systems of classification and tabulation; more especially as regards accuracy and completeness of information, and economy of labour and cost in compilation. Finally, in the fifth part of the paper, the author urged the necessity for an international consideration of the subject, with a view to the statistical and surgical histories of campaigns being constructed on a general system common to the medical departments of all regular armies.

Dr. ALTHAUS said that Mr. Longmore had made an error in stating that no record of the wounded was kept in the German army. Both in the dressing-places to which wounded men were first taken, and in the movable hospitals, the nature of each case and its treatment were noted; and the same was done in the field-hospitals. In this way, very complete statistics of the Danish war had been obtained; and it was highly probable that a very complete account of the injuries received in the recent war would appear.—Staff-Surgeon FITZGERALD said that in the German army a note of each case was indeed made; but there were no numerical returns made out at the dressing-places or in the movable hospitals. The question of recording individual cases was quite distinct from that of numerical returns. What was wanted was, that each surgeon should furnish a return of this kind. He had been employed in compiling the records of the Crimean war, and had had occasion to notice the defects in the returns of primary amputation—there not being sufficient information as to the injuries for which the operations were performed.—Mr. SPENCER WELLS pointed out a source of fallacy which he had noticed while on duty in war; that the same man may receive more than one wound, and thus be entered more than once on the returns.

### MEDICAL SOCIETY OF LONDON.

MONDAY, MARCH 6TH, 1871.

JOHN GAY, Esq., President, in the Chair.

MR. W. F. TEEVAN read a paper on the Pathology and Treatment of Stricture of the Urethra. He defined stricture to be "any diminution of the natural calibre of the urethra, the result of the contraction of organised lymph." In this country there was but a vague and undefined idea as to the commencement of stricture, for most surgeons would consider that, if in a given case a No. 10 catheter could be passed, there could be no stricture: hence this most serious pathological fact was presented, that the urethra might dwindle down to one-third of its normal calibre without the change being either recognised or suspected. It was of the utmost importance to detect and cure a stricture in its incipency and so obviate all recourse to any operative procedure. If stricture were diagnosed and cured in its primary stage, an enormous boon would be conferred on mankind, for the renal organs

would be spared the ill effects of a long-standing stricture. As a rule, it was not the fault or neglect of the patient that prevented the diagnosis of stricture in its early stage, for the surgeon had several years' warning of the advent of the disease; inasmuch as, if there were one complaint more than another which worried a patient, it was the persistent presence of a gleet, and for its cure the sufferer went about from hospital to hospital. It might be laid down as a general rule that, if a patient had suffered from gleet for several months, there was always some important pathological alteration, the most serious of which was contraction. The use of the ball-staff would reveal the slightest diminution of the calibre of the urethra—years before its mechanical results to the stream of urine would be apparent. Stricture might, regarding its seat, be divided into subpubic, penile, and orificial. The most common form of stricture was the subpubic, situated at the triangular ligament; and the division of that variety into bulbous and membranous was artificial and not warranted by any facts. Penile strictures were found at a spot varying from two-and-a-half to three-and-a-half inches from the external meatus. Strictures at the orifice were rare, and were usually caused by some chancrous ulceration. Of a given number of strictures, 80 per cent. would be found to be subpubic; 18 per cent. penile; and 2 per cent. orificial. Strictures in their physical conformation might be divided into two great classes: those which he called tunnel-strictures, as they conveyed to the ball-staff the sensation of travelling through a contracted channel; and, secondly, those which imparted to the *bougie-à-boule* the feeling of passing through a sharp and well-defined ring. Most subpubic strictures were of the tunnel kind, whilst penile strictures were as often tunnel-shaped as ring-like, and orificial strictures were nearly always of the last kind. He had measured the length of the urethra in one hundred males of adult age, and found that the average measurement was seven and one-eighth inches. Nearly all subpubic strictures would be ascertained to be situate at a spot five inches and a half from the meatus externus. From practical inquiry, he had found that the subpubic urethra would admit the little finger without laceration, thus exhibiting a calibre three times as large as a No. 10 English catheter. All means which had not for their end the restoration of the urethra to its normal diameter would fail to effect a permanent cure of a stricture; so that if the canal, by dilatation, rupture, or incision, were only enlarged to a diameter less than its normal capacity, there would infallibly be a return of the contraction, unless from time to time the diameter of the tube were kept up to that to which it was extended. In severe cases of stricture, only the smallest filiform bougie could be introduced, and with patience and perseverance it would rarely fail of entry; but if it could not, after prolonged trial, be made to pass into the bladder, then such a case was a fit and proper one for external urethrotomy. Whatever treatment might be adopted for stricture, it would appear that such treatment must always be followed, and nearly always preceded, by gradual dilatation. It thus was evident that there was only one treatment *par excellence*—that by gradual dilatation by the French flexible bougies: all other methods were merely auxiliaries. The bougie could dispense with the services of the dilator or urethrotome, but they were impotent and mischievous without the aid of the bougie. In a certain number of limited cases dilatation could only be effected to a certain point, or, if it were carried beyond this, the stricture speedily contracted again. Such strictures ought to be incised or split. Which was the better method? That which the more completely carried out the indications of surgical pathology in such a case. It was a well-known law that a lacerated wound was attended with greater contraction than an incised one; so that, if a stricture required an operation, that operation ought to be a cutting one, and not a tearing one. Forcible dilatation of the urethra for stricture would seem to be sharing the same fate in this country as in Paris, for it had been discontinued by Sir William Ferguson, Mr. Coulson, Mr. Henry Smith, and other surgeons. The objections to forcible rupture were its not unknown sequences of death, abscess, retention of urine, hæmorrhage, and calculus forming on the clot. He knew of fifteen deaths which had occurred in the practice of different hospital surgeons from the use of dilators. *Post mortem* examination after forcible rupture showed laceration of the mucous membrane. Mr. Teevan concluded by stating that the treatment of stricture might be thus summed up: 1. Gradual dilatation wherever possible; 2. Subcutaneous division wherever desirable; 3. External urethrotomy wherever necessitated.—Mr. MAC CORMAC considered that the majority of strictures could be well treated by gradual dilatation. If the profession carried out Mr. Teevan's instructions regarding the importance of an early diagnosis of stricture, there would be no necessity for any operative procedure.—Mr. HENRY SMITH was strongly opposed to forcible dilatation, as it was followed by relapses and death. He was entirely in favour of gradual dilatation.—Mr. J. D. HILL approved of forcible rupture of stricture, and practised it. He

had, however, had two fatal results in his practice after use of the dilator.—Mr. DAVY had witnessed various methods of treating stricture, and he certainly liked forcible rupture. He considered the *bougie à boule* a most valuable instrument, and it ought to be used as Mr. Teevan had advocated.—Mr. GANT used the dilator in a few exceptional cases, preferring gradual dilatation for the majority of strictures.

## CLINICAL SOCIETY OF LONDON.

FRIDAY, MARCH 24TH, 1871.

W. W. GULL, M.D., F.R.S., President, in the Chair.

Dr. DUFFIN read notes of two cases of Roseola Variolosa. In the first, six hours after a severe rigor, a thickly set papular rash appeared. It was strictly confined to the surface of the abdomen and the inside of the thighs, thus occupying a triangular space, with its base upwards. The rash blanched on pressure. The patient presented the signs of severe febrile disturbance. After forty-eight hours the eruption became purpuric, and at the end of an additional twenty-four hours uniformly confluent. The regular papules of small-pox then appeared on the face. The patient had two imperfect vaccine marks on his arm. The case ran a moderately severe course up to the period of the secondary fever, when the disease aborted. In the second case, a papular rash, in all respects similar to the other, appeared on the arms and thighs of a girl, twenty-four hours after severe rigors. The rash here also became purpuric on the third day, and on the fourth a modified small-pox eruption occupied the face. This patient also had been vaccinated. In reliance on the descriptions of Hebra and Trousseau, Dr. Duffin contended that, where these limited rashes occurred, they were pathognomic of the appearance of small-pox, the diagnosis of which would be much accelerated. In vaccinated subjects they had little prognostic importance, but in the unvaccinated they were extremely formidable. No proper small-pox rash seemed to invade the purpuric area, which gradually faded as the disease evolved.—Dr. FAGGE saw a patient some time ago with the rash, and next day there were papules of small-pox. A man came with purpuric blotches, and passing blood. He died, as Dr. Wilks thought, from small-pox; but he had been ill over forty-eight hours, and there were no papules. Nevertheless, twelve days thereafter several patients in the same ward and the ward-clerk were attacked with true small-pox, there having been no other case in the ward.—Dr. HABERSHON thought the early diagnosis of small-pox often far from easy. The roseola was not always confined to the abdomen. Sometimes it extended to the hands and arms, or other parts of the body.—Dr. RASCH referred to a case in which a lady, who had visited him whilst ill, was attacked with a rash resembling scarlatina on the abdomen. One small-pox pustule followed.—Dr. BROADBENT had altogether seen eight cases like those mentioned by Dr. Fagge. The first exactly resembled a case of scarlatina, but was rather deeper in tint. There were slight throat-symptoms; hæmorrhage followed, and the patient died. There were no papules, though life was prolonged to the fourth day. The rash had been more or less general in all he had seen. With the eruption there had been a period of absolute comfort. Hæmorrhage had come on, and death followed.—Dr. A. P. STEWART had been called to a case of doubtful diagnosis. Twelve days before his visit, a scarlatinal eruption had appeared, with sore-throat. The rash had faded, and slight desquamation was going on, when the patient was seized with a rigor, and on the twelfth day pustules, completely formed in less than thirty hours, appeared on the hands and feet. Was this small-pox? The crusts formed were like those of impetigo.—Dr. SIBSON had seen a similar case.—Dr. SUTTON also affirmed that the early diagnosis of small-pox was not easy. He also had seen cases with roseolous rash over the abdomen.—Dr. DUFFIN had seen another case since the paper was written.—The PRESIDENT had often made a better diagnosis by not looking at the patient with premonitory symptoms of small-pox. Syphilis was most frequently taken for it. They sometimes died with the purpura. He had seen an old gentleman who had had small-pox in his youth, but was again attacked, and died bleeding at every pore on the fourth day as the papules were appearing.

Mr. CHRISTOPHER HEATH read notes of a case of complicated Stricture of the Urethra treated by Mr. Syme's operation for Impermeable Urethra. A discharged soldier, aged 28, upon whom external urethrotomy had been performed in India, had an impassable stricture of the urethra, complicated with perineal fistule, and an old false passage of considerable length. The patient had been under careful treatment for six months before he came under Mr. Heath's care; but no instrument could be passed into the bladder, nor was Mr. Heath more successful after several careful trials. He therefore adopted Mr. Syme's suggestion, and introduced a director through one of the fistulæ into the urethra behind the stricture, then passed a steel staff along the urethra

and made it meet the director, and thus enter the bladder. Instead of then cutting upon the staff and dividing the stricture, as suggested by Mr. Syme, Mr. Heath preferred to pass Holt's dilator along the urethra and split the stricture; and this was successfully accomplished. The patient made a good recovery, and was taught to pass his own instrument, which he continues to do to the present time.—Mr. MAUNDER objected to forced catheterism, and he did not think that in this case the track of the urethra had been followed. A false passage had been formed, and a granulating wound produced, which would end in new contraction. It would be impossible to keep this new passage open. He would have selected a variety of perineal section. In all cases a bristle can be passed; the stricture may then be gradually dilated, and cut through.—Mr. TEEVAN remarked that, in all operations for stricture, if such were required, cutting methods were preferable to those which effected their purpose by laceration. He considered it a bad plan to leave a catheter in the bladder after these operations, as it only tended to set up irritations, and promote the formations of a fistula.—Mr. BARWELL had recently examined a man on whom, some years before, he had performed Syme's operation. He had a good urethra. He thought it best to cut through the hard mass. It was difficult to keep the urethra open, and close a fistula.—Mr. COOPER FORSTER thought Mr. Heath's plan reasonable. He found a fistula, and he took advantage of it; if such an one were not found, it was better to make it. Ordinarily, the urethra was dilated behind the stricture; they might cut into this, and then take off the urine regularly, and thus give the stricture rest before operating. He had searched a good many times, without finding anything like an urethra.—Mr. HAWARD was surprised to find no reference to puncture from the rectum; he had seen it afford great comfort to the patient and relief to the stricture.—Mr. CROFT thought that Mr. Heath's case demanded a special line of treatment.—Mr. SMITH used to lay open the stricture and try to force a catheter into the bladder.—Mr. REEVES had seen both Mr. Maunder and Mr. J. Adams manage to pass a bristle through an almost impermeable stricture.—Mr. HEATH said that Mr. Syme's plan was not his; they had become mixed up in the debate. In his case there was a long false passage, so that he could not know where to cut. He did not employ forcible catheterism; he had a guide to the bladder. Mr. Teevan's experience seemed to be somewhat exceptional. Cutting sometimes led to fatal hæmorrhage.

Mr. TEEVAN narrated the particulars of the treatment adopted in a case of Retention of Urine from Impassable Stricture in a man, aged 46, who had suffered from severe organic stricture for ten years, and from retention, with dribbling, for nearly one year. At last, complete retention set in, and he was taken to a hospital, where, after an unsuccessful attempt to pass a catheter, he was relieved by a hot-bath and medicine. A few days later, he came under Mr. Teevan's care for his complaint. He still followed his occupation as cab-driver, as the continual dribbling relieved him. Mr. Teevan tried for half-an hour unsuccessfully to pass the smallest elastic catheters and bougies, and when he renewed his attempts two days afterwards, he met with the same want of success. The following day complete retention set in; and at four o'clock the next morning he was taken to Mr. Teevan, who succeeded, after a quarter of an hour's trial, in passing the No. 1 smallest filiform bougie, which was only about one-fifth of an English No. 1; and having allowed the instrument to remain in for ten minutes, he withdrew it, when a very fine stream of urine began to flow, and continued for an hour, when nearly three quarts of urine had been passed. The patient was afterwards cured of his stricture by gradual dilatation. Mr. Teevan called the case one of impassable stricture, as no catheter could be passed for the relief of the retention. He brought it forward to show what the filiform bougie could achieve in an apparently hopeless case for its successful use. The occurrence of the retention facilitated the passage of a bougie, and therefore, if the patient had been put into a hot-bath, which would probably have been useless, as the weather was very hot, he would have lost a valuable opportunity presented him for commencing that treatment by gradual dilatation, which relieved the retention and ultimately cured the stricture. The bougie had, in this case, saved the patient an operation.—Mr. REEVES had tried these bougies, and had found them often to double up.—Mr. HEATH congratulated Mr. Teevan in being able to pass a bougie in such a case.—Mr. CROFT said that, at St. Thomas's, they often passed cat-cut guides first of all. There was also a plan of pressing against the stricture for a time, after which it might become passable.—Mr. MAUNDER had the highest opinion of the value of these French bougies, and he regretted he was unable to procure any more from Paris. Experience and care entirely obviated the possible occurrence of the incident mentioned by Mr. Reeves. Gentle handling was the great secret.—Mr. TEEVAN said that, in inserting such fine bougies, they should be withdrawn a quarter of an inch for every half inch of progress made. Had he failed, he would have tied the man up, and cut into his bladder.

## PATHOLOGICAL SOCIETY OF DUBLIN.

SATURDAY, MARCH 11TH, 1871.

JAMES STANNUS HUGHES, M.D., President, in the Chair.

Dr. JAMES LITTLE showed a Heart in which there was extreme Narrowing of the Mitral Orifice, the tip of the little finger being with difficulty inserted into the opening. The right ventricle was much dilated, but not hypertrophied; the left ventricle was greatly hypertrophied. To the latter pathological change Dr. Little directed especial attention in its relation to mitral constriction. Bright's disease, permanent patency of the aortic valves, and the existence of a general atheromatous condition of the arterial vessels, were mentioned as the remaining principal causes of hypertrophy of the left ventricle of the heart. In the present instance, a well defined and localised *frémissement cataire* was audible during life over the apex of the heart, a sign of which Dr. Gee has spoken as indicative of mitral obstructive disease.

Dr. R. W. SMITH presented an example of Partial Fracture of the Bones of the Forearm. The patient, a young man, had, by being caught in a machine, received numerous injuries, which had resulted in his death. There were compound fractures of the humerus, and of the bones of one forearm; also fractures of the femur and of the skull; the bones of the other forearm had suffered a complete fracture near their upper extremities, while the ulna was partially broken two inches and a half, and the radius three inches, above the wrist-joint. The lesion did not consist in a mere bending of the bones; for, while there was no interruption of continuity of the osseous fibres on the anterior aspect of the bones, their posterior portions were undoubtedly fractured. The case was one which solved what had long been a more or less uncertain point. Many of the fractures described as partial were in reality complete, the bones retaining a curvature in consequence of an interlocking of the fragments occurring on their concave aspect. Again, a simple bending of various bones was often mistaken for a partial fracture. In the present instance, however, a true "sally-switch" fracture had occurred. Dr. Smith alluded to a paper on the subject which had been published in the first volume of the *Dublin Journal of Medical Science* by the late Dr. Hart, Professor of Anatomy in the College of Surgeons of Ireland.

Dr. STOKES exhibited a specimen of Non-ulcerated Cancer of the Stomach, the disease having been accompanied by the usual symptoms—pain, vomiting, loss of appetite, wasting, with more or less anæmia. There was no obstruction of the pylorus, and the presence of an abdominal tumour could be detected by physical examination only at times. Hypodermic injection of morphia had proved of great use in the treatment of the case, a decided amelioration of the patient's general state having taken place under its employment. A slight ascites was observed at the time of the man's admission to hospital; and on this fact Dr. Stokes laid great stress, pointing out the diagnostic value of the existence of a limited and stationary ascites as indicating the probable presence of carcinoma, where evidences of chronic peritonitis were wanting. On *post mortem* examination, the submucous coat of the stomach was found to be the seat of an extensive cancerous degeneration. The structure partook of the characters of both scirrhus and encephaloma, and afforded a good example of the gelatiniform carcinoma of Cruveilhier. The great omentum was studded with cancerous tubercles, and the surface of the hepatic peritoneum was rough from the presence of numerous hard nodules of very minute size. The mixed nature of the morbid growth went to confirm Cruveilhier's views as to the structure of cancer. That author describes scirrhus and encephaloma as being modifications of the same growth, which consists of a fibrous framework enclosing a cancerous juice. In hard cancer, the fibrous materials are present in excess; in encephaloid disease, they are less in amount than the fluid constituents. Dr. Stokes then proceeded to review our present knowledge of cancer in general. He considered that the origin of the disease was not to be attributed to any inflammatory process, and he believed that we possessed no scientific means of detecting any characteristic, microscopical or chemical, of the affection. With Cruveilhier, he looked upon cancer as specific in its nature. Its formations, again, were found in relation rather with the venous than with the arterial system; and they did not produce irritative changes in surrounding structures. The disease was a process of *conversion*, and, as such, affected fluids as well as solids. An example of this was met with in the change of an empyema into a soft encephaloid mass. Lastly, the rapid growth of cancer was a remarkable feature in its history.

BEQUESTS.—By the will of Mrs. Mary Woodiwis, the Manchester Royal Infirmary receives a legacy of £1000; and St. Mary's Hospital, Manchester, £500.