

CASE II.—Stephen B., aged 42, under treatment for cirrhosis of liver, had suffered greatly from want of sleep. Urethan was ordered in doses of fifteen grains every hour till sleep should be obtained. Four doses were given before he fell asleep. He woke again very soon after, and was given another dose, when he again fell asleep, but not for very long. He was in great pain most of the night; he vomited a number of times. This he was often in the habit of doing before admission, and was especially liable to it when, as was the case this night, he slept in the recumbent position, it being usually his habit to sleep sitting up in a chair, to avoid sickness. Next morning he vomited several times, but he very often used to vomit in the morning, though, on this occasion, it was rather more severe than usual, and there was greater nausea. The pulse was full, strong, and 76.

On the whole, in these cases the drug was found to produce sleep without causing bad symptoms or injuriously affecting the secretions.

REPORTS OF SOCIETIES.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, JULY 7th, 1886.

J. B. POTTER, M.D., President, in the Chair.

Specimens.—The following specimens were shown. 1. Dr. DALY: Growth removed from Uterus after delivery. 2. Mr. DORAN: Malformations of the Fallopian tubes. 3. Dr. GALABIN: Growth removed from Cervix Uteri of a girl only 17 years old. 4. Dr. W. S. A. GRIFFITH: Portions of Ovaries resembling Cystic Chorion.

Case of Simultaneous Removal of Ovarian Tumour and Fibro-Myoma of Uterus.—Mr. KNOWSLEY THORNTON gave details of the fatal termination of this case, from which the specimens which he showed at the previous meeting were removed.

A Case of Chronic Abscess of the Female Urethra.—This contribution was read by Dr. HERMAN. The patient, aged 47, had suffered for four years from dysuria, and about two years from dyspareunia, and irritability of bladder, these symptoms gradually increasing in severity during this time. There was a tender swelling between the urethra and the vagina, which burst into the urethra, pus being discharged. Examination with the finger through the dilated urethra, eight days afterwards, showed that the cavity was then about the size of half a walnut, with a soft, ragged friable wall. Its interior was cauterised with nitrate of silver, and it soon contracted and disappeared. Four months afterwards the patient continued quite well. The author thought that there were two possible explanations of the origin of the abscess. 1. That it was the result of chronic congestion of the urethra, such as that described by Sir C. M. Clarke. 2. That it was a suppurating cyst. Abscess from either of these causes was rare. He quoted three cases that he had been able to find recorded. He gave reasons for thinking that the abscess in his case was probably not a suppurated cyst, and that the case was therefore to be classed with those of congestion of the urethra described by Sir C. Clarke and Dr. West.—Dr. DALY said that, in a case of congestion of the female urethra, which had resisted all treatment, the patient being for months confined to bed, and suffering intense pain, he applied iodoform every day along the entire course of the urethra, and obtained a rapid cure. The application was made by filling the groove of a director with iodoform, and when the director was well in the urethra, reversing the direction of the groove. He had to thank Dr. Herman for the suggestion.—Dr. MATTHEWS DUNCAN had seen many abscesses in the recto-vaginal septum, but he remembered none in the urethro-vaginal septum. Chronic urethritis he had often seen, and also some cases of urethrocele.—Dr. GERVIS, though surprised at the statement in Dr. Herman's paper, as to the rarity of the condition described, could certainly only at the moment recall one case. In this the symptoms had been painful micturition without evidence of cystitis and of pain, and swelling and tenderness referred to the vagina. On examination, an abscess was found in the anterior vaginal wall, in association with the urethra; and, the same evening, probably as a result of the examination, which included the passage of a sound into the bladder, it burst into the urethra, and the patient made a good recovery.—Mr. KNOWSLEY THORNTON had seen a few cases of the kind. He would raise the question as to whether the condition described by Sir C. Clarke was the same as that for which Dr. Emmet, of New York, had invented a special operation. If so, the condition must be much more common in America than in this country.—Dr. WYLLIE, of New York, said that the condition for which Emmet's operation was chiefly used, was prolapse of the mucous membrane of the urethra in elderly females.—Mr. DORAN referred to an interesting

case of a diverticulum in the female urethra, described by Santesson, of Stockholm, and published in the *London Medical Record*, March, 1885. The symptoms were very puzzling until the parts had been explored.—Drs. GALABIN and M. HANDFIELD JONES also made remarks, and Dr. HERMAN replied.

Observations on the Uterine Bruit.—The author, Dr. CHAMPNEYS, recorded a series of observations on this point, some of which had been already noted in this country, others abroad, and some were related, it was believed, for the first time. The first series included forty-six nearly continuous observations, made at the General Lying-in Hospital, regarding: (1) The Position of the Maximum Intensity before Labour; (2) After the Expulsion of the Placenta; (3) The Presence of Pulsating Arteries felt by the Vagina, and the effect produced on the Bruit by their Compression. The bruit was heard on the left side in thirty-three cases, and on the right side in one case. It was heard after the expulsion of the placenta in five cases. In all cases when heard after the expulsion of the placenta, its point of greatest intensity had sunk down after delivery. In five cases, a pulsating artery was felt in the vagina, pressure on it affected the bruit in one case only. The preponderance of left-sided over right-sided bruits, confirmed the view that the bruit was produced in the arteries as they reached the uterus, or soon after, for the left cornu of the uterus was anterior to the right (dextral torsion). One observation concerned a case of placenta prævia, in which the bruit and the placenta were on the left side. The author analysed Rapin's and Rolter's papers, the latter of which concerned the relation between a uterine bruit which was heard, and a thrill which was felt. The author recorded two cases in illustration of the same point, and one instance in which the same observation was made in the case of a fibroid tumour of the uterus, and one in which the necropsy seemed to show that a uterine bruit was situated in a large sinus, running over the surface of a fibroid tumour.—Dr. GERVIS asked why Dr. Champneys adopted the term "palpable bruit" to express the perception of a localised pulsation, and also whether, in the course of his observations, he had found corroborative evidence of Dr. Hick's suggestions as to the effect of the uterine contractions on the characters of the soufflé.—Dr. HERMAN thought that the variations in loudness of the murmur, to which Dr. Gervis had referred, were of much importance in its identification. There was no kind of abdominal enlargement in which a murmur, having rhythmical variations in loudness, was heard, excepting that produced by uterine tumours. The presence of such a murmur showed that the tumour was uterine, but did not give any further information as to its nature. The murmur might be, as a rule, louder, and the variations more marked in pregnancy than in fibroids, but he had heard murmurs over some fibroids louder than those on some cases of pregnancy. The murmur was not to be relied upon for the diagnosis between fibroid and pregnancy.—Dr. JOHN PHILLIPS asked if Dr. Champneys had any experience in vaginal stethoscopy, and if so, whether it was corroborative of the hypogastric signs. He was aware that there was naturally a certain feeling of aversion to this method of diagnosis, but thought that, if any facts of scientific value could be thus obtained, it might be permissible, or even advisable.—Dr. A. ROUTH asked how long the uterine soufflé persisted (1) after labour; (2) after the death of the fetus in utero. He had seen a case at Charing Cross Hospital where labour had to be induced for uncontrollable vomiting, in which vaginal stethoscopy proved the soufflé to exist two or three weeks after the presumed death of the fetus, which was mummified, the soufflé being inaudible over the abdomen. He had frequently heard the soufflé through the vagina over the cervix uteri, when it was inaudible over the abdomen; and, so far as his experience went, he had found that, whenever the soufflé of a pregnant uterus was audible over an abdominal area, it was also audible over the cervix uteri *per vaginam*. In one case of the soufflé being heard in the abdomen over the site of a uterine fibroid, it was not audible over the cervix uteri. If this distinction of the area of diffusion of the soufflé of pregnancy and of that of a uterine tumour be trustworthy, it would serve as a material aid in differential diagnosis.—Dr. W. S. A. GRIFFITH thought that the dextro torsion of the uterus, which only occurred to a very limited extent, was by itself insufficient to explain the frequent absence of the uterine soufflé on the right side. Some other explanation was wanted, which applied equally to the cases in which it was absent on both sides. The great cause of the bruit was almost certainly the passage of blood suddenly from a small into a larger channel at the junction of the uterine arteries and sinuses.—Drs. GALABIN and M. HANDFIELD JONES also made remarks.—Dr. CHAMPNEYS, in reply, said that the subject was so large, that he had not attempted a complete study of it. In this sense, his observations were confessedly imperfect. By palpable uterine bruit, he meant a bruit which was also palpable as a thrill. He was inclined to agree

with Dr. Herman that marked rising in pitch was characteristic of the *souffle* in pregnant uterus rather than in fibroid. He had not used the vaginal stethoscope, as the gain was very questionable, and the objections obvious. He had never observed diastole in the *souffle*. The *souffle* was often musical, the various notes forming a sort of chord, and this pointed to their being produced by many vibrating bodies. He could not answer the question as to the exact length of time that the *souffle* was audible after delivery, without referring to his hospital-notes. The entrance of blood from a small into a large cavity was probably the chief cause of the *souffle*, but there were many other sufficient causes, such as the sudden curves in the arteries, the quality of the blood, etc. To eliminate these was difficult.

SOUTH INDIAN BRANCH.

FRIDAY, MARCH 5TH, 1886.

Surgeon-Major J. J. L. RATTON, M.D., in the Chair.

Paralysis of Vocal Cords.—Dr. J. SMYTH related the history of a patient, a Hindu, aged 35, who was admitted on December 25th, 1885, on account of orthopnoea, dysphagia, and emaciation with cyanosis. Difficulty in swallowing had existed for six years, dyspnoea for about nine months. There was slight œdema of the neck and lower extremities; the veins of the arm and the long thoracic veins were prominent. The dyspnoea was distinctly laryngeal and inspiratory; expiration was free. With the laryngoscope it was seen that during rest the cords were in apposition, except along their posterior two-thirds; that during inspiration, after the first third of the act, the cords came completely together, and that the width of the aperture of the glottis never exceeded $\frac{1}{4}$ inch. The right pulse was fuller than the left; the dyspnoea became so distressing on the evening of admission, that it was necessary to perform tracheotomy, which was followed by immediate relief. Dysphagia and regurgitation of food persisted, but the patient's health became, in other respects, much improved. Dr. Smyth considered that the diagnosis lay between aneurysm of the transverse, or descending parts of the aortic arch, and enlarged bronchial glands; the former hypothesis appeared to be negated by the absence of the physical signs of aneurysm which, as the paralysis was bilateral, must have affected the transverse part, or the beginning of the descending part of the arch, and would probably have produced dulness and pressure on the trachea. There was a history of repeated cough, with expectoration and fever, and he considered that most probably the bronchial glands were enlarged.—Dr. RATTON asked whether the possible existence of an abscess had been considered.—Mr. MAITLAND suggested that chloride of calcium, which had been largely used by Dr. Warburton Begbie in the treatment of glandular enlargements, should be administered.—Mr. NAILER suggested that the paralysis might not be secondary to enlargement of glands, but primary and due to syphilis.

Naso-pharyngeal Polypus.—Dr. RATTON described two operations which he had recently performed for large naso-pharyngeal polypi. In the first case he performed Rougé's operation, in which the upper lip is reflected so as to expose the anterior nares; the tumour was then pushed back into the pharynx, the pedicle snipped through, and hæmorrhage checked with perchloride of iron. The wound having healed, the patient left the hospital on the eighth day. In the second case, in which the nasal cavities were not dilated, but the soft palate was pressed forward, the soft palate was divided, the polypus was pulled to one side by a ligature passed through it. The tumour, which grew from the periosteum, was then detached with a guarded blunt-pointed bistoury, and hæmorrhage checked by direct pressure with a sponge. The patient, a boy, aged 12, was discharged in six days. Dr. Ratton pointed out that one or other of the operations described greatly facilitated the removal of naso-pharyngeal polypi.

ACADEMY OF MEDICINE IN IRELAND:

SURGICAL SECTION.

FRIDAY, MAY 21ST, 1886.

Sir CHARLES A. CAMERON, M.D., President, in the Chair.

A Case of Ununited Fracture of the Humerus and a Method of Treatment thereof by Metal Screw-Taps.—Mr. HENRY FITZGIBBON exhibited a brace fitted with drills and screw-taps for the fixation of resected bones, and reported the case which he had successfully operated upon by this method. Mr. T. was admitted into the City of Dublin Hospital, March 13th, 1885, with comminuted fracture of humerus, which would not unite. An operation was performed on November 26th, by means of screw-taps and wire suture, which were removed on the twenty-first day after operation. The patient was ex-

hibited to the Academy with firm union and a useful arm on April 16th. Mr. FITZGIBBON attributed the non-union to the pressure of the comminuted fragment being displaced inwards, so as to cause pressure upon the brachial vessels, depriving the lower fragment of sufficient blood-supply.—Mr. BENNETT admitted that in this case the union was perfect not only as regarded junction of the bones, but also in their apposition and the line of direction of the humerus, so that there was little or no deformity. In mechanical detail, Mr. FITZGIBBON'S method offered some advantages; but iron pegs were preferable to silver, as being rigid and efficient, while the silver were flexible.—Mr. WHEELER, having seen the patient before, during, and since the operation, mentioned the result of his observation. In his own practice he observed a noteworthy point which he had not seen recorded in the books; namely, that in fracture of the humerus, where there was much mobility, if the bone united, a great mass of callus was thrown out, and that was always on the inner side.—Mr. O'GRADY said that ununited fractures varied so much in their conditions that no one line of treatment could be laid down. He had used ivory pegs till it was suggested that the pigs from which the material was obtained might have had tuberculosis, and thenceforward he used the plain iron pegs, which were driven by means of the common Archimedean drill with an up and down movement. His drill was that which the late Mr. Hutton once possessed. In the after-treatment he adopted the strictest antiseptic procedure, cleanliness and rest, but without the newly-developed paraphernalia.—Mr. CORLEY said that there were already nineteen different methods for the treatment of ununited fracture, the large number suggesting that none of them could be regarded as perfect. Mr. FITZGIBBON formed the twentieth, which he hoped would be perfect. He approved of the ordinary Archimedean drill.—Mr. MARBLE mentioned the advantage of using a steel gimlet, with a thread the size of the screw, as giving a hold, and obviating the detritus which Mr. FITZGIBBON'S instrument produced. He had used ivory screws, which became loosened sufficiently to draw out.—Mr. TOBIN considered that it was an interesting question to determine how long would the sore bite in the bone, seeing that it ultimately loosened.—Mr. FRANKS, about a year and a half ago, had himself treated a case of ununited fracture of the humerus. The fracture passed through the neck of the bone below the attachment of the capsular ligament. The case had been wrongly diagnosed as a dislocation, and put into splints. At the end of six weeks, it was sent up from the country to him. He found the lower fragment projecting underneath the skin, which was so extremely thin, that he feared the slightest movement would send the bone through it. Having decided to remove part of the bone, he exposed it by an incision from the shoulder, and he then removed about two inches of the lower fragment. From the upper one, he could take nothing, because it was bound by the capsular ligament. He scraped the bone to revivify it; then, with an ordinary bradawl, he drilled two holes through the head of the bone, passing through the capsular ligament, and two the other way, through the lower fragment, and inserted two tolerably thick silver wires, joining and twisting them. Six months afterwards he removed the wires, which, but for the irritation they caused, he would have let remain. He used more antiseptic precautions than cleanliness and rest. He preferred passing the wires through, and thus joining the ununited bones as a simpler method than using screws. The less the surgeon trusted to complicated methods, and the more he used his fingers, the better.

Electrolysis for the Treatment of Urethral Stricture.—Mr. P. J. HAYES read a paper on the treatment of urethral stricture by electrolysis, the comparatively novel method practised by Drs. Robert Newman, of New York, and S. T. Anderson, of Bloomington. He gave the details of three cases, in which he had himself adopted the method with encouraging results. He strongly advocated the trial of electrolysis, even for the most complicated forms of stricture. It did not at all interfere with the subsequent employment of other measures, minor or serious. Electrolysis was best adapted for the treatment of annular strictures rather limited in length. Having ascertained the situation of the stricture, the tip or exposed metal bulb of an electrode ought, if possible, to be lodged within it; or, if this was impracticable, the tip must be in close contact with the anterior face of the stricture. Then a small galvanic battery was connected by its negative pole with the urethral electrode, whilst the positive might be attached either to a moist sponge electrode, or, better still, to a thin metal plate covered with moistened chamois-leather. The positive electrode would be advantageously applied either to the patient's perineum, or against the inner side of one thigh. As to the strength of the current to be employed, the patient's own sensations would prove the best guide. The current should be perceived, but it ought not to be pushed to cause pain, nor should the surgeon attempt more than it was needful to effect

at each sitting, using only mild currents, and manipulating the electrode with gentleness, and never pushing it through the stricture, as it accomplished more by being allowed to remain in the stricture than by being caused to quickly traverse it. The sittings might be repeated every ten days, if desired. Cauterising would be produced when strong currents were employed; but, with mild currents, the gradual breaking up of fibroid tissue was effected by a combination of chemical decomposition and vital absorption until but a thin lamella of cicatricial tissue remained to mark the seat of the stricture.—THE PRESIDENT, Mr. FITZGIBBON, Mr. TOBIN, Mr. BENNETT, Mr. CORLEY, and Mr. WHEELER, took part in the discussion; and Mr. HAYES replied.

REVIEWS AND NOTICES.

VON ZIEMSEN'S HANDBOOK OF GENERAL THERAPEUTICS, Vol. v. GENERAL ORTHOPÆDICS, GYMNASTICS, AND MASSAGE; by Professor Dr. FRIEDRICH BUSCH, of Berlin; translated by NOBLE SMITH, F.R.C.S. ED. HYDRO-THERAPEUTICS; by Dr. W. WINTERNITZ, of Kaltenlentgehen, near Vienna; translated by F. W. ELSNER, Medical Officer to the Peninsular and Oriental Steamship Company, London. London: Smith, Elder, and Co. 1886.

THE first part of this volume, dealing with Orthopædics, Gymnastics, and Massage, commences with a review of gymnastics in the past, from the Olympian games of the Greeks down to the more modern gymnastics of the French, German, and Swedish schools. Considerable attention is said to have been paid to "massage" since 1870; but, as a method of treatment, it may fairly claim a more venerable antiquity, seeing that formal directions were given for its employment many centuries before the Christian era. The author's selection of words to express the male and female operators cannot be altogether approved, either in English or French. "Rebouteur" in French, and "bone-setter" in English, are equivalent expressions, and both convey a meaning quite distinct from that of "masseur." We doubt, too, whether the designation "dames blanches" would be understood except in hydropathic establishments. Again, "shampooing," a word of Indian origin, has nothing, strictly speaking, in common with massage, of which Martial sings:

Percurrit agili corpus arte tractatrix
Manumque doctam spargit omnibus membris,

these being the very movements which have since been developed into a special cure by Swedish medical gymnasts.

Due credit is given to Dr. Mezger, of Amsterdam, for his able advocacy of the system, but the directions which follow for anointing the hands prior to the massage are distinctly at variance with the plan advocated by him, according to which the hand used should be soft and dry. The *modus operandi* of employing the various kinds of massage, the *effleurage*, the *pétrissage*, etc., are briefly alluded to, with cautions as to their indiscriminate use.

Of the value of systematic gymnastic exercise in promoting the health and vigour of the race, no doubt can be entertained, and the importance attached to it for military purposes cannot easily be overrated. Its practice in schools is, of course, liable to be accompanied by accidents of more or less gravity, but these must be accepted as an unavoidable risk. *Nil prodest quod non ledere possit idem.*

Orthopædics, taken in the widest sense, is a description of the nature of deformities of the human body, and also the means of redressing them. Such deformities may be brought about by defective formation, or from the effect of weight or traction. In some cases, the mechanism is tolerably simple, while in others it baffles our ingenuity to account for. As a general rule, deformities resulting from defects in first formation are not curable, but all congenital deformities do not arise from this source, and the common congenital club-foot is a good example of an exception.

Deformities of the vertebral column naturally take up a large share of the author's attention. The principal varieties, lordosis, scoliosis, etc., are carefully gone into, and their treatment, by mechanical means and otherwise, is exhaustively discussed. The pernicious effects of certain positions, amusements, and occupations are explained, and "cure by prevention" raised to the dignity of an art. It is obviously of extreme importance that the influence of certain manners or customs, in accentuating any pre-existing disposition to deformity, should be understood, and, consequently, avoided. The nursing of babies, or the carriage of weighty articles habitually on one side, may, like the attitude of violin-playing, start or favour the development of spinal curvature. In their earlier stages, these deformities are peculiarly amenable to treatment by means of proper muscular exercise, excepting, of

course, the cases due to intrinsic destructive disease of the vertebrae themselves. A series of woodcuts are furnished to illustrate the plan to be followed in exercising particular muscles, or groups of muscles. The practice of tenotomy, as advocated by Jules Guérin, meets with scant sympathy at the author's hands; and the reasons for its condemnation appear conclusive. The use of the wedge-shaped pieces of cork, worn by girls for the purpose of looking "coquettish," has, on the other hand, been attended with considerable benefit in incipient curvatures, by raising the side of the pelvis corresponding to the convexity of the lumbar curve.

The indications given for the employment of various orthopædic apparatus, in the treatment of spinal curvatures, are very complete; and will be found extremely useful by practitioners called upon to exercise their patience and skill in remedying these distressing distortions. The careful enunciation of the principles which should guide us in their treatment will, moreover, enable the practical surgeon to devise suitable apparatus for particular cases; and this is the more important, since it is obvious that no hard-and-fast rules can be applicable to the varying conditions which may present themselves.

The value of gymnastics and massage, in the treatment of other than orthopædic complaints, is separately considered, and their efficacy, in the relief of certain classes of muscular and joint pains, when judiciously combined, is evidently very great. Lumbago, sciatica, and muscular spasm, together with stiffness and limitation of the movements of joints, and even stuttering and chorea, are all said to be, more or less, amenable to this form of treatment, which has the merit of being always at hand. The beneficial effect of certain exercises, especially rowing with sliding-seats, in the chronic lung-affections, is alluded to; wherever available, it offers a pleasant means of improving the health.

The treatise on Hydro-therapeutics, by Dr. W. WINTERNITZ, covers to some extent the same ground as that in Vol. 4, by Professor Leichtenstern, on Balneotherapeutics, although from a somewhat different point of view. The bibliographical index which precedes the volume and contains references to the literature on the subject, from the time of Hippocrates down to our own day, extends over upwards of thirty-four pages, and serves to show how much this question of "water cure" has occupied men's minds in the past. Public feeling has alternated between unbounded faith and the most uncompromising contempt. The success of the movement, in many instances, was probably due to the peculiar qualities of the promoter or promoters; and, when their influence was withdrawn, the practice fell into disrepute. The discredit, which at other times was the lot of this system of treatment, was largely owing to the fact that it was *exploité* by men whose ignorance of medicine and diagnosis in particular was only equalled by their self-confidence, and science and common sense were only too frequently foreign to its advocacy and its employment. It is a curious fact that during the middle ages—and indeed in our own times to some extent—progress was effected by reverting to plans of treatment long discarded. The only glimpses of rational treatment of disease during the "dark ages," were when some bold spirit broke away from the idle speculations which then occupied the time, and absorbed the energy of the Faculty, and followed the teaching of Hippocrates in its simplicity. Of this teaching, the use of water, internally and externally, formed an essential part. The change was generally welcomed, until on the principle of the *reductio ad absurdum*, it was made to authorise the administration of five pounds of iced water every three hours to the unhappy sufferer, and analogous excesses.

The history of this department is very conscientiously gone into, and is replete with interest. When we see so illustrious a person as Boerhave, gravely declaring *hoc remedium non proponitur nisi in desperatis casibus*, we can only wonder why he came to this conclusion. During the eighteenth century, hydrotherapy made serious strides, it became generally recognised as suitable for "carrying off the tough and sticky humours which take up their abode in the capillaries." On the strength of this revival of popularity a number of individuals, for the most part "humberging charlatans," as the author, or rather the translator styles them, contrived to obtain notoriety, and one of them—Priessnitz—died worth several millions (of francs?). While in England the utility of cold in the treatment of certain diseases was gradually recognised, and Chapman's spinal ice-bags were introduced, the renowned dermatologist Hebra formulates an emphatic disapproval of these "aquatic sports," as he terms them.

The physiological and therapeutical effects of warm and cold baths, etc., are discussed with an evident desire to place the subject once for all on a scientific basis. Their influence on the circulation, and on nutrition generally, together with the variations of sensibility and reflex nervous phenomena produced by their use under different cir-